

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | TUESDAY, JULY 6, 1982 | | 9:30 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | FEB. 26, 1887 | | 95 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | USA | | | | BALTIMORE CITY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORKER OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | 3300 CLARKS LANE APT. B (21215) | | MANAGER | | LEBOW CLOTHES | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| MARYLAND | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3300 CLARKS LANE APT. B (21215) | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE BRANCH AND DATES) | | 16b. SOCIAL SECURITY NO. | |
| NATHAN | | ABRAHAM | | YES <input checked="" type="checkbox"/> WWI 1 - ARMY | | 215-10-9357A | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | 19. DATE OF OPERATION | | 20a. AUTOPSY? | |
| MRS. ETTA ABRAHAM | | 3300 CLARKS LANE APT. B (21215) | | 4100 | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASLVD</u> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | 11/2 | |
| | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 22c. DATE SIGNED | |
| | | HOUR A.M. MONTH DAY YEAR | | | | 7-6-82 | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| saw the deceased alive on | | DR. MAURICE FELDMAN MD | | 7-6-82 | | | |
| above, (I) (we) (did) (did not) view the body after death | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | DR. MAURICE FELDMAN | | 6610 CROSS COUNTRY | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 7-7-82 | | HEBREW FRIENDSHIP CEM. | | BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., INC. | | JUL 8 1982 | | [Signature] | | | |
| 6010 REISTERSTOWN RD., BALTO., MD. (21215) | | | | | | | |



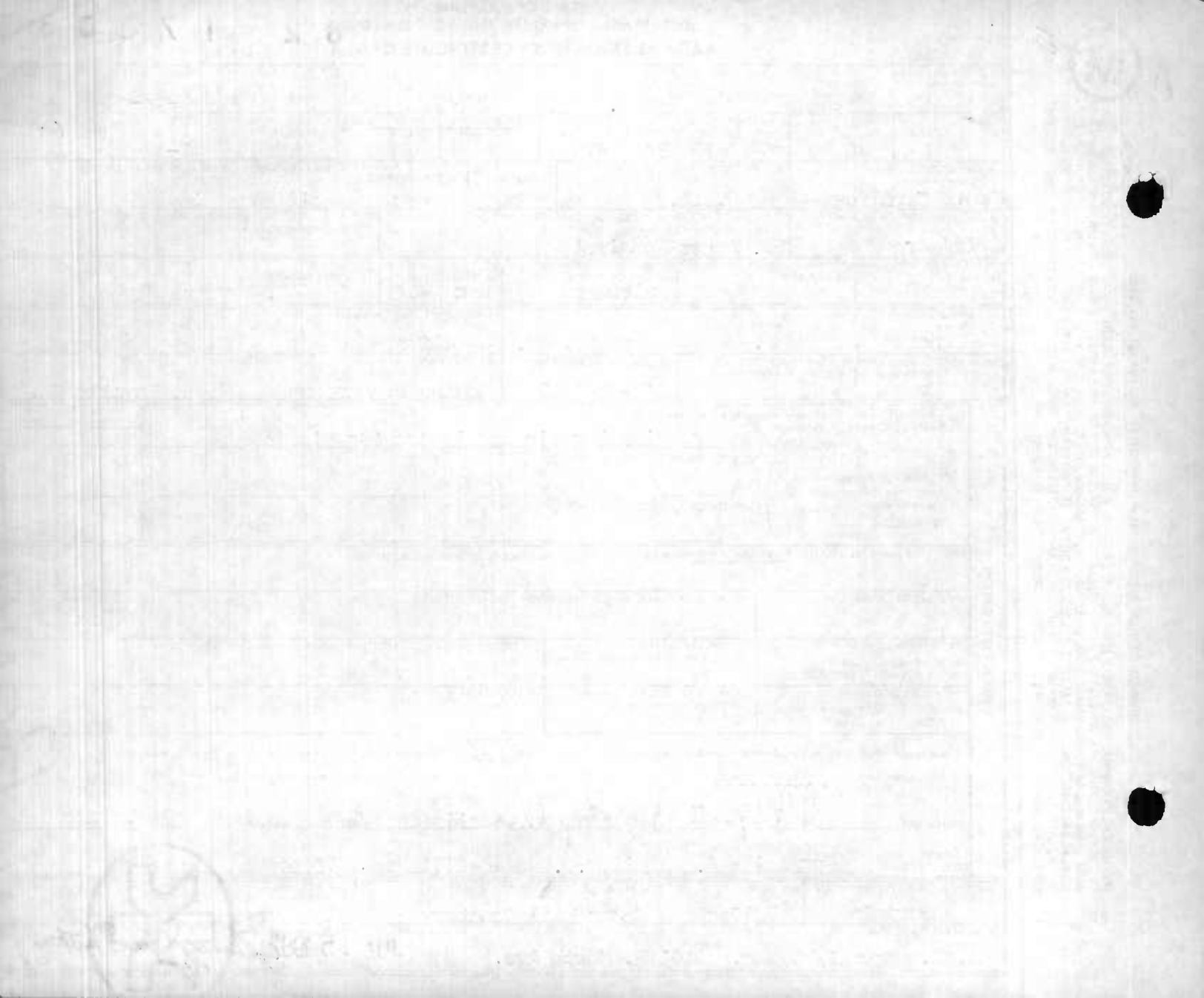
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|---------------------|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ERNEST H. ABRAHAM | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 7-12-82 | | | 2b. HOUR M 2:29P | | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 6 10 34 | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD 7-12-82 | 2d. HOUR M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest H. Abraham, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Madison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 247-42-5632 | | 17. INFORMANT ADDRESS Louise B. Abraham 2046 E. Fayette St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER DATE SIGNED 7-13-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | 25a. DATE REC'D BY REGISTRAR JUL 15 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Frances Jean Nathan</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use in the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 3 0 4 |
|---|--|--|-------------------|---|-------|---|-----------------------|--|--|---------------|
| 1- FOR STATE REGISTRAR | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR | | |
| FIRST MIDDLE LAST Agnes MARIE Adams | | | 7 | | 12 82 | | 12 ³⁵ A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| FEMALE | | WHITE | | MONTH DAY YEAR 9 23 17 | | 64 YRS | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Virginia | | U.S.A. | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Baltimore City Hospital | | | | Manager-Snack | | Bar America | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | |
| Maryland | | Baltimore | | Dundalk YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2075 Larkhall Road | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST Oscar Hamilton | | | | FIRST MIDDLE LAST Nellie May Dackery | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | 213-12-2051 | | Vester I. Adams 2075 Larkhall Rd. Balto., MD. 21222 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| 4039 IMMEDIATE CAUSE (a) Cardio pulmonary collapse | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) acute renal failure | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) severe hypertension | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | | |
| 22a. INJURY OCCURRED | | 22b. PLACE OF INJURY | | 22c. LOCATION | | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22d. I certify that (I) (this hospital) attended the deceased from 7/12/82 to 7/12/82, that (I) (we) lost saw the deceased alive on 7/12/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (each) did not view the body after death. | | | | | | | | | | |
| 22e. SIGNATURE | | | | DEGREE | | | | 22f. DATE SIGNED | | |
| [Signature] | | | | | | | | 7/12/82 | | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22h. ADDRESS | | | | | | |
| Wayne Stahl | | | | Baltimore City Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | 23e. STATE | | |
| Burial | | 7/14/1982 | | Holly Hill | | White Marsh | | Maryland | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | JUL 14 1982 | | [Signature] | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN W. ADAMS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/12/82 | | 2b. HOUR 8:20PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 3 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL, BALTIMORE, MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer | | 12b. KIND OF BUSINESS OR INDUSTRY Meat Packing Co | |
| 13a. STATE Maryland | | | | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lambertine Adams | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Todd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-03-3021 | | 17. INFORMANT ADDRESS Mary Gilbert 406 3rd, Ave. 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) LEFT LUNG PNEUMONIA & RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC GRANULOCYTIC LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF (c) 3 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 06-26 , 19 82 , to 07-12 , 19 82 , that (I) (we) last saw the deceased alive on 07-12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Philip M Lam | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 07-12-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP M LAM | | | | 22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 24b. ADDRESS 21229 | | 25a. DATE RECORDED BY REGISTRAR JUL 14 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE Thomas J. Math | | | | | | | | | |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17306 | |
|--|--|---|--|--|--|---|--|--|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) Phillip Adams | | | | | | | | | | 2b. DATE KNOWN OF DEATH 7 30 19 82 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH 7 14 1964 | | 6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 7 30 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1020 Argyle Avenue (on street) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1020 Argyle Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Adams | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marie White | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Rose Marie Adams 1020 Argyle Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest (unspecified) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:15 PM 7 30 19 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1020 Argyle Avenue, Baltimore, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: gunshot wound <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-30-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm C. Brown Comm. F/H 1206-08 W. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | 25b. REGISTRAR'S SIGNATURE Hormez R. Guard | | | |



RECEIVED
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CHB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 3 0 7
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY S. ADAMSKI Sr. | | 2a. DATE OF DEATH MONTH DAY YEAR 7 9 1982 | | 2b. HOUR 11 30 AM | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 12 5 1915 | | 6. AGE (IN YEARS; LAST BIRTHDAY) 66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Id | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5705 White Ave | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY | | |

| | | | | | |
|---|--|---|---------------------------------------|---|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 5705 White Ave |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leon Adamski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Swandowski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, (GIVE WAR OR DATES) OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-05-9817 | | 17. INFORMANT ADDRESS Veronica Adamski 5705 White Ave | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

| | | | | | |
|--|--|---|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/2 , 19 80 , to 7/9 , 19 82 , that (I) (we) last saw the deceased alive on 7/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert T. Parker M.D. | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/9/1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. PARKER, M.D. | | 22e. ADDRESS Good Samaritan Hospital | | | |

| | | | |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL Burial | 23b. DATE 7-12-82 | 23c. NAME OF CEMETERY OR CREMATORY St. Louis | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond K. Kozanski 2525 White Ave | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 12 1982 Frances Jan Thartin | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be
obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 3 0 8
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|-----------------------|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emma Ader | | | 2a. DATE OF DEATH MONTH DAY YEAR July 16, 1982 | | 2b. HOUR 4:10 a.m. | | | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 12-20-1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY — | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3015 E. MONUMENT ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LUDWIG GEYER | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH PETRI | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 212-74-7876 | | 17. INFORMANT ADDRESS Mrs. Alice E. D'Amico - 12 Arway Circle | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Heart Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Months 25 Years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that X (this hospital) attended the deceased from July 8, 19 82, to July 16, 19 82, that X (we) lost saw the deceased alive on July 16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Tommy T. Hsu M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) T Tommy Hsu, M.D. | | | | 22e. ADDRESS C/O Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR NAME Stanley Miller - 7527 Sanford Rd. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan [Signature] | | | |

REBORN 10/10/2000

Original in file - 7527 - 10/10/2000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|---|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | 7 2 1 7 3 0 9 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy Adkins</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 7, 1982</i> | | | | | 2b. HOUR M | |
| 3 SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 29, 1918</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Balto. City</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pimlico Manor</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>---</i> 13c. CITY OR TOWN <i>Balto. City</i> | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>2914 Rayshire Drive 21221</i> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Jones</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Grindley</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | | | | 16b. SOCIAL SECURITY NO. <i>215-12-3254 A</i> | | 17. INFORMANT'S NAME AND ADDRESS <i>Mrs. Carl Adkins 2914 Rayshire Dr. Baltimore, MD. 21221</i> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>(PROBABLE) ACUTE CORONARY ARTERY OCCLUSION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>ILEOSTOMY; COLOSTOMY; HISTORY OF PELVIC CANCER</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>JULY 2, 1982</i> to <i>JULY 7, 1982</i> that (I) <i>last</i> saw the deceased alive on <i>JULY 2, 1982</i> and that in (my) <i>last</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did not</i> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Ian Sunshine, M.D.</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>7/8/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Ian Sunshine</i> | | 22e. ADDRESS <i>6210 Park Heights Avenue</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>Burial</i> | | 23b. DATE <i>7-9-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore, Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors, Inc.</i> 8728 Liberty Road Randallstown, MD. 21133 | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 8 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i> | | | |



MIN

21/11



HELENGLOSS/SCHIFFER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for death certification is death occurred within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been assigned by the funeral director, it should be detached for use as the burial-transit permit. The funeral director should file a copy of this certificate with the State Dept. of Health and Mental Hygiene prior to the funeral, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 1 0 | | | |
|---|--|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Andres J Alarcon</u> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>7/17/82</u> | | 2b. HOUR <u>2:29 AM</u> | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>C</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>5/31/48</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>34</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Chile</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>Y</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balt City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ of MD Hosp</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Manager-Business</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | |
| 13a. STATE <u>Virginia</u> | | 13b. COUNTY <u>York</u> | | 13c. CITY OR TOWN <u>Alexandria</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Jose Alarcon</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Esther Vega</u> | | 13e. STREET ADDRESS <u>1202 S. Washington St.</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>225-96-4687</u> | | 17. INFORMANT ADDRESS <u>Ma. Hector Alarcon Alexandria Va. 22314</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>2051</u> IMMEDIATE CAUSE (a) <u>cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic myelogenous Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> 19 <u>82</u> to <u>7/17</u> 19 <u>82</u> , that (I) (we) lost the deceased alive on <u>7/17</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>J. N. Pomeroy, MD</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/17/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Pomeroy, MD</u> | | 22e. ADDRESS <u>Univ of MD Hosp</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u> | | 23b. DATE <u>17 July 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SECURITY Process Inc</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Herbert E. Nutter</u> | | ADDRESS <u>Balto Md. 21216</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 20 1982</u> REGISTRAR'S SIGNATURE <u>James J. Nathan</u> | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

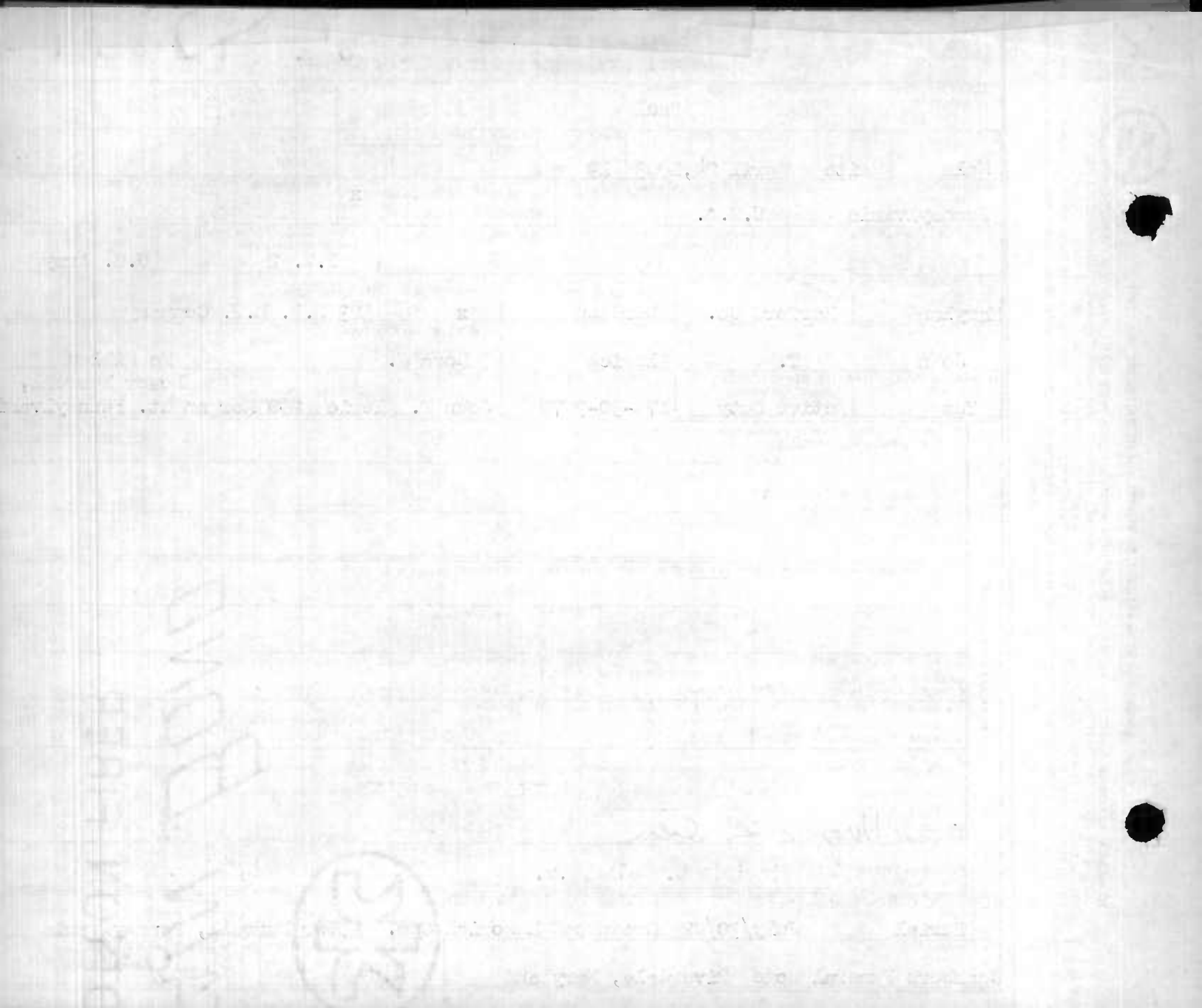
BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|------------------------------|-------------------------|---|-------------------------|-----------------------|--------------------------------------|---------------------------|--|--|----------------------------------|---------------------------------------|
| 1. FOR STATE REGISTRAR | | 20. DATE KNOWN OF DEATH | | 21. DATE OF ESTI-MATED | | 22. DATE OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE KNOWN OF DEATH | | 21. DATE OF ESTI-MATED | | 22. DATE OF DEATH | | 23. DATE OF DEATH | | 24. DATE OF DEATH | |
| Benton Paul Alerich | | 7 26 19 82 | | 7 26 19 82 | | 7 26 19 82 | | 7 26 19 82 | | 7 26 19 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 13. KIND OF BUSINESS OR INDUSTRY | 14. BALTIMORE CITY OR COUNTY OF DEATH |
| Male | White | April 24, 1963 | 19 YRS. | | | Baltimore City | Baltimore | University Hospital STU | P.V. 2 | U.S. Army | Baltimore City |
| 15. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 16. CITIZEN OF WHAT COUNTRY? | 17. MARRIED | 18. NEVER MARRIED | 19. WIDOWED | 20. DIVORCED | | | | | | |
| Pennsylvania | U.S.A. | | | | | | | | | | |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 22. STATE | 23. COUNTY | 24. CITY OR TOWN | 25. INSIDE CITY LIMITS? | 26. STREET ADDRESS | | | | | | |
| Maryland | | Harford Co. | Aberdeen | YES | 523 R.D. M.P. Company | | | | | | |
| 27. FATHER'S NAME | 28. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| John T. Alerich | Dora J. Mc Millen | | | | | | | | | | |
| 29. WAS DECEASED EVER IN U.S. ARMED FORCES? | 30. SOCIAL SECURITY NO. | 31. INFORMANT | | | | | | | | | |
| Yes | Active Duty | 176-50-9979 | John T. Alerich 200 Morgan St. Pennsylvania | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Blunt injury to head | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | |
| 20. AUTOPSY? | | | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | | | | | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | |
| 21b. TIME OF INJURY | | | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 3:52 PM 7/24 19 82 | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| driver motorcylce lost control | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | | | | | | | |
| roadway | | | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | | | |
| STREET CITY OR TOWN | | | | | | | | | | | |
| PlazaCentreParkingLot, Northeast, Aberdeen, MD | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | | | | | | | | | | |
| Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | |
| Virginia L. Dolan | | | | | | | | | | | |
| TITLE (SPECIFY) | | | | | | | | | | | |
| Assistant | | | | | | | | | | | |
| M.D. MEDICAL EXAMINER | | | | | | | | | | | |
| DATE SIGNED | | | | | | | | | | | |
| 7/26/82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | |
| 111 Penn Street, Balto. MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | | |
| Burial | | | | | | | | | | | |
| 23b. DATE | | | | | | | | | | | |
| July/30/82 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | |
| Greenwood Memorial Cem. | | | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | | | |
| CITY OR TOWN | | | | | | | | | | | |
| Lower Burrell, Pennsylvania | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | |
| NAME | | | | | | | | | | | |
| Chambers Funeral Home | | | | | | | | | | | |
| ADDRESS | | | | | | | | | | | |
| Riverdale, Maryland | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | |
| AUG 3 1982 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| [Signature] | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

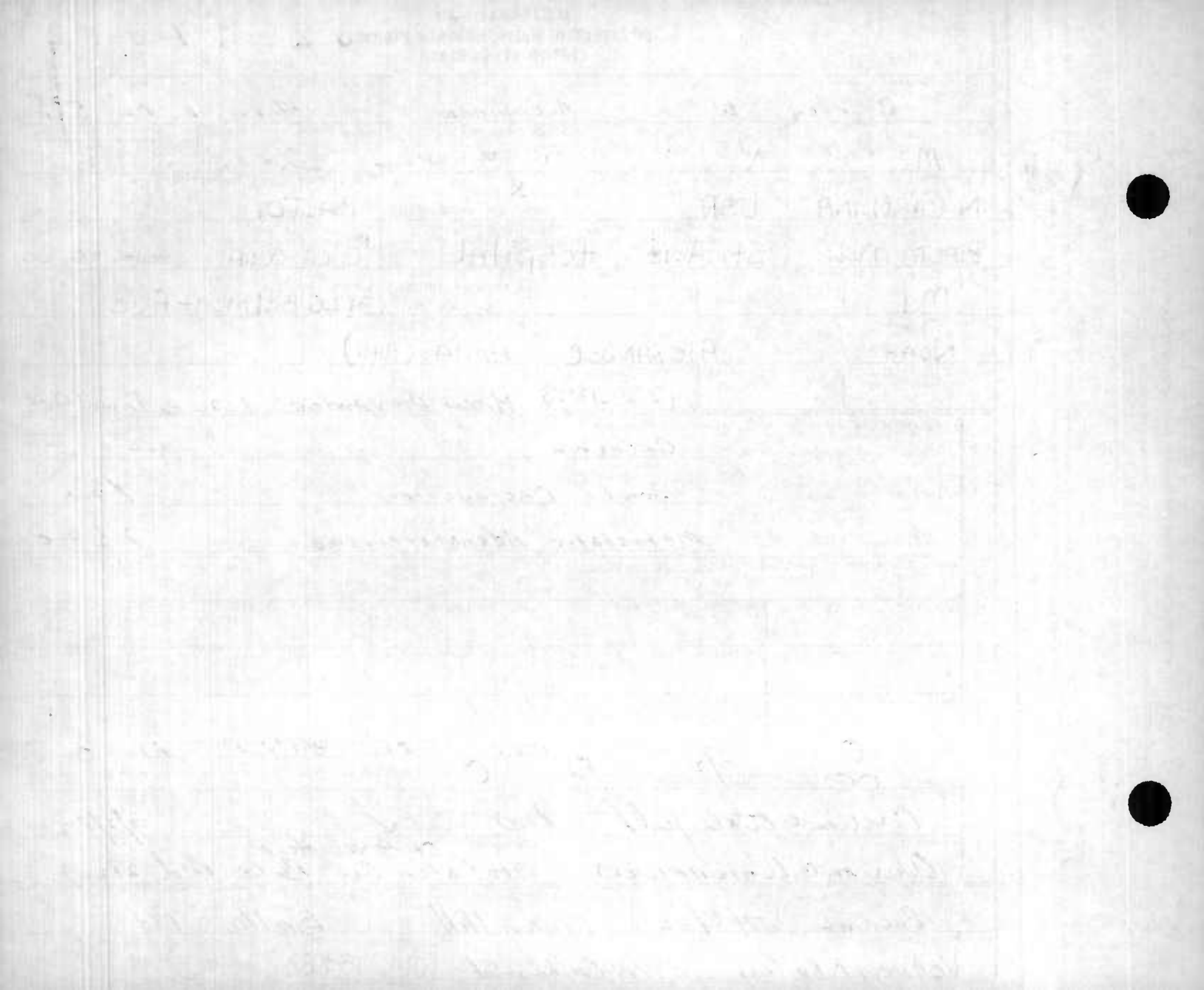
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 7 3 1 2

| | | | | | |
|---|---------------------|---|--|---|--------------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) CLIFTON W. ALEXANDER | | | 2a. DATE OF DEATH MONTH July DAY 2 YEAR 82 | | 2b. HOUR 5²⁵ PM |
| 3. SEX M | 4. RACE N | 5. DATE OF BIRTH MONTH 3 DAY 3 YEAR 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH BALTO. Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. MD. | |
| 12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) COCA-COLA | | | 12b. KIND OF BUSINESS OR INDUSTRY BOTTLING Co. | | |
| 13a. STATE Md | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST NOAH MIDDLE LAST ALEXANDER | | 15. MOTHER'S MAIDEN NAME FIRST ANNA (HALL) MIDDLE LAST | | 13e. STREET ADDRESS 3120 Belmont Ave | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 24220-1398 | | 17. INFORMANT Mary Alexander ADDRESS 3120 Belmont Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Adenocarcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. 2 1/2 mo. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from May 19 82 , to July 2 19 82 , that (1) (we) lost saw the deceased alive on 7/2 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William C. Waterfields | | 22c. DATE SIGNED 7/2/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Waterfields | |
| 22e. ADDRESS St Agnes Hosp 900 Caton Ave Balto Md 21229 | | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | |
| 23d. LOCATION CITY OR TOWN Balto. COUNTY Md STATE | | 24. FUNERAL DIRECTOR NAME Vernon R. Bailey ADDRESS 1348 N. Calhoun St. | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Muriel G. Alexander | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 7 82 | | 2b. HOUR 3:00 PM |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 10 - 27 - 23 | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE MD | 13b. COUNTY — | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 22 S. Abington Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Gaskins | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aiken Huy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS Eric Alexander 22. S. Abington Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) COLD, Corpulmonalis, Severe pulmonary DUE TO, OR AS A CONSEQUENCE OF fibrosis 2° to sarcoidosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7- 19 82 , to 7-7 19 82 , that (I) (we) lost saw the deceased alive on 7-7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kaushalendra K. Singh | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAUSHALENDRA K. SINGH | | | 22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AV. BALTIMORE. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 7/12/82 | 23c. NAME OF CEMETERY OR CREMATORY BALTO NAT'L CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | |
| 24. FUNERAL DIRECTOR NAME VERNON R. Bailey | | | ADDRESS 1348 N. Calhoun St. | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 |
| | | | 25b. REGISTRAR'S SIGNATURE Thomas J. Anthony | | |

United States of America

300-3 30 2 2

RECEIVED
JUL 15 1965



JUL 15 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8-2 17314 | |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) BLANCHE G. ALGER | | | 2a. DATE OF DEATH MONTH DAY YEAR July 4, 1982 | | 2b. HOUR 9:30 A M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 624 1/2 Colorado Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Dean | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude McMahon | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 214 16 6644 | | 17. INFORMANT ADDRESS Mary E. Stevenson, Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) CHF - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden. 20+ years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Ca of the heart | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1958, 19 to July 4, 1982, that (I) (we) last saw the deceased alive on June 30, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 23a. SIGNATURE Dr. Joseph Matchar, M.D. | | | | 23b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Matchar, M.D. | | | | 23d. ADDRESS 3635 Old Court Rd., Balto., Md. | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23f. DATE 7/8/82 | | 23g. NAME OF CEMETERY OR CREMATORY Dulaney Valley | |
| 23h. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md. | | 23i. DATE REC'D. BY REGISTRAR JUL 6 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | |

NOT RECORDED

1901 OCT 10

Burial

2355 - Culinary Valley

Cal. Co.

Henry W. Jantke & Son Co.

1905 York Road, El Paso, Tex. 79905

Dr. Joseph West, M.D.

1905 Old Court Rd., El Paso, Tex.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SPENCER ALSTON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 82 | | | | | 2b. HOUR 1 a M |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 28 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 71 | | 8. IF UNDER 24 HRS HOURS MIN. 1 a M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N C. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 713 Exeter Hall | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Boss Alston | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odelia Alston | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS Burnest Alston 1203 Rossiter Avenue | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) Metastatic Renal Cell CA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Acidosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 82 , to 7/28 , 19 82 , that (I) (we) last saw the deceased alive on 7/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Carl Sperling MD | | | | DEGREE MD | | | | 22c. DATE SIGNED 7/28/82 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLING, M.D. | | | | 22f. ADDRESS 201 E UNIVERSITY PKWAY | | | | 22g. STATE Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-31-82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natten | | | | |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

8 2 1 7 3 1 6

REG. NO.

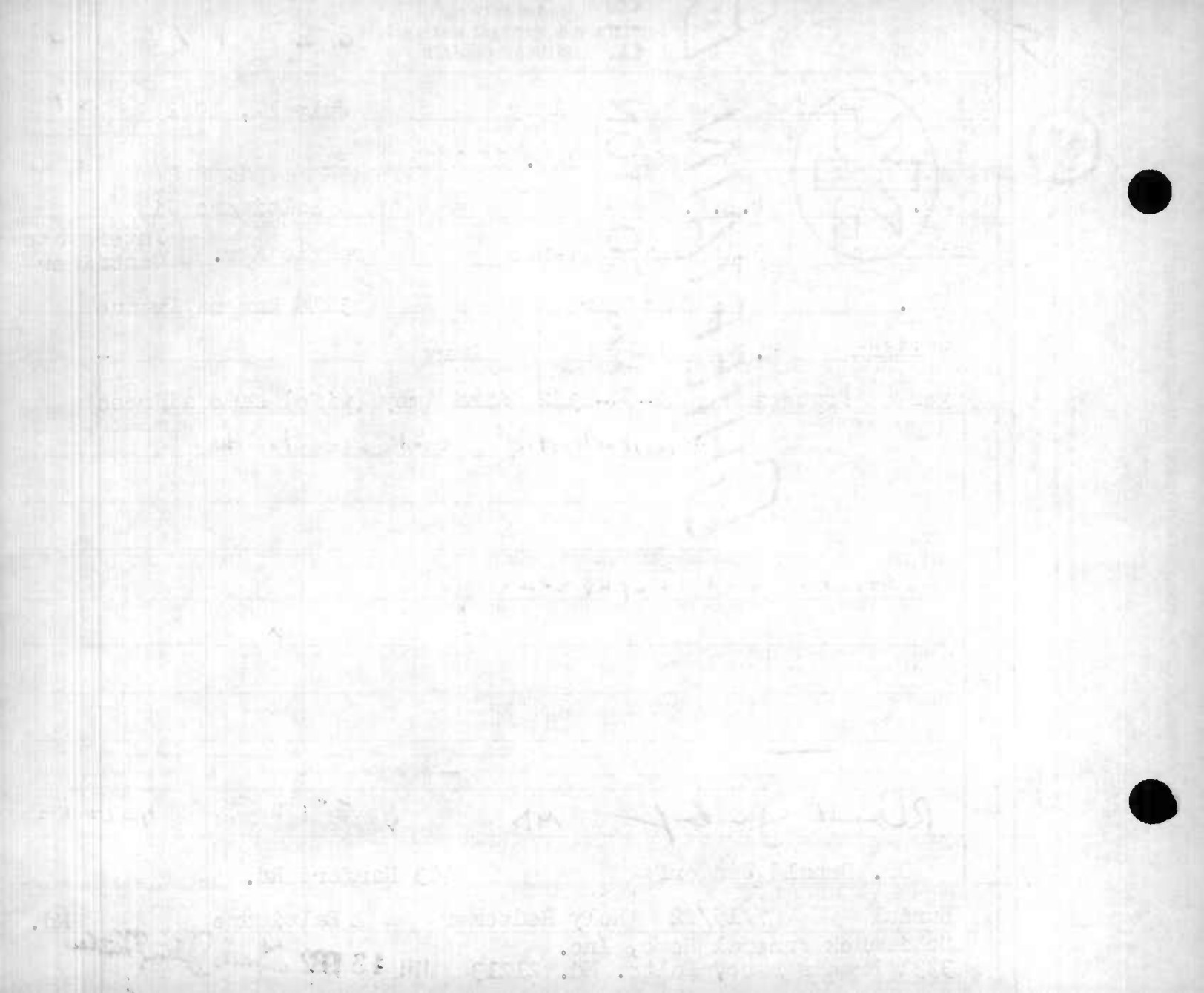
1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) William Amey | | | 2a. DATE OF DEATH MONTH DAY YEAR July 11, 1982 | | 2b. HOUR 8 P.M. |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 15 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3218 Ramona Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Traffic Mgr. | 12b. KIND OF BUSINESS OR INDUSTRY Interstate Container | |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3218 Ramona Avenue |
| 14. FATHER'S NAME FIRST MIDDLE LAST William R. Amey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes Peacetime | | 16b. SOCIAL SECURITY NO. 212-09-2382 | 17. INFORMANT ADDRESS Anna Amey (wife) same address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular dis. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Stroke and emphysema | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Donald Jandorf | | DEGREE MD | | 22c. DATE SIGNED 7-12-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Donald Jandorf | | 22e. ADDRESS 7403 Harford Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/15/82 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR (NAME) Schlimmek Funeral Home, Inc. | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |
| 24. ADDRESS 3331 Brehms Lane, Balto, Md. 21213 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified in advance.

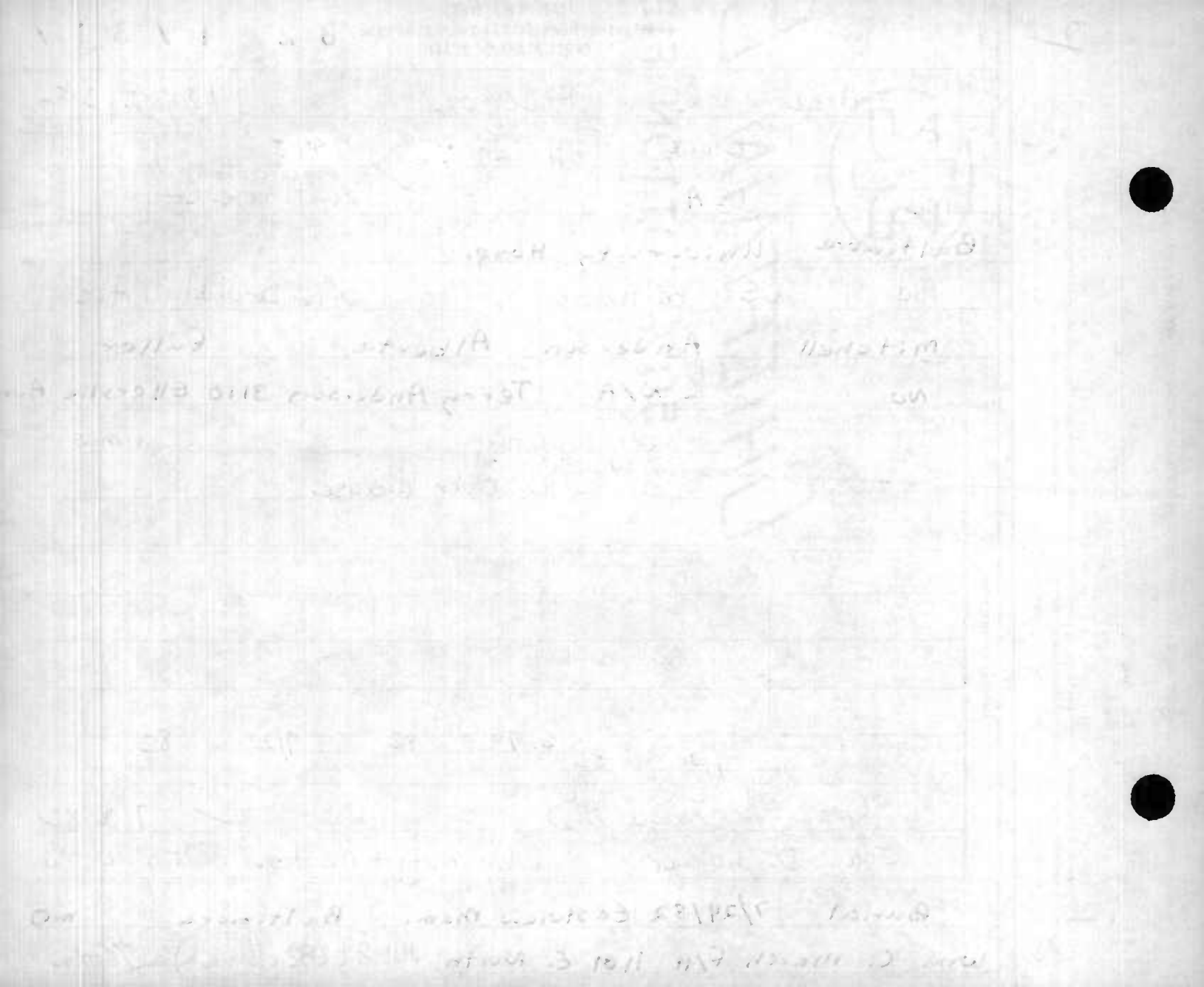


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 3 1 7 | | | |
|---|--|--|--|--|--|---|--|--|--|--|-----|--|----------------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Alice | | R | | Anderson | | | | 7 | | 20 | 82 | 355 | A _M |
| SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| F | | Black | | 11 27 36 | | 45 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| md | | USA | | | | Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | University Hosp. | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | |
| md | | US | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2446 Druidhill Ave | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| Mitchell | | | | Anderson | | | | Alberta Fuller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | N/A | | Terry Anderson | | | | 3110 Ellerslie Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 5713 | | | | | | | | | | | | 1 mas | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | |
| (b) alcoholic liver disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF: | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/18 19 82, to 7/20 19 82, that (I) (we) last saw the deceased alive on 7/20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| Joan D. Longer MD | | | | | | | | 7/20/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| Joan D. Longer | | | | University of Md Hosp Baltimore, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | | | 7/24/82 | | Eastview Mem. | | Baltimore | | COUNTY STATE MD | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME | | | | ADDRESS | | | | | | | | | |
| Wm. C. March F/H | | | | 1101 E. North | | | | JUL 21 1982 Frances Jan Nathan | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 7 2 1 7 3 1 8 | |
| 1. DECEASED NAME (TYPE OR PRINT) CHARLIE | | 2. DATE OF DEATH MONTH DAY YEAR 7/31/82 | |
| 3. SEX MALE | | 4. RACE NEGRO | |
| 5. DATE OF BIRTH MONTH DAY YEAR 4 15 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hosp. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY BALTO. | |
| 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 2429 Cybura Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Paris Anderson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isaiah Kiefer | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 216-05-9517 | |
| 17. INFORMANT ADDRESS Pauline Clayburn 816 N. Mount St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIA Arrest. 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CA of Lung DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/30 , 19 82 , to 7/31 , 19 82 , that (I) (we) last saw the deceased alive on 7/31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Edward Franco | | 22c. DEGREE M.D. | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD FRANCO | | 22e. ADDRESS 3423 ARCADIA DR 71043 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/7/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | |
| 24. FUNERAL DIRECTOR NAME E.L. Philips | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | |
| 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

MEDICAL CERTIFICATION

11/10/11

CHIEFMAN

200 COLL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM-16 50M/1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

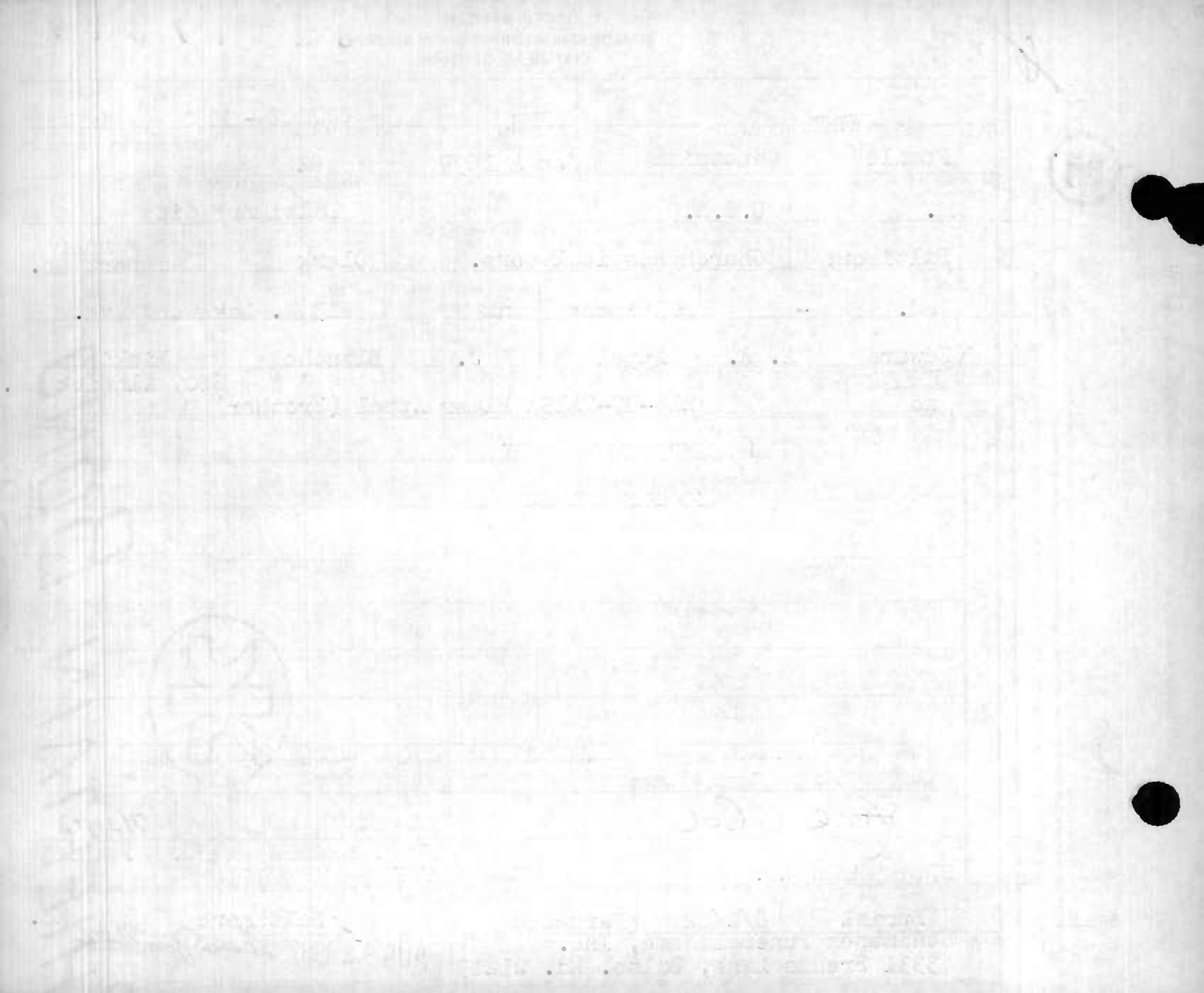
8 2 1 7 3 1 9

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL APPEL | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 31, - 1982 | | 2b. HOUR 1:30 A.M. |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Sept 4 1899 | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 8b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Warner Lambert Co. |
| 13a. STATE Md. | | | 13b. COUNTY - | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward A. A. Appel | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST J. Blanche Miskimon | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | 16b. SOCIAL SECURITY NO. 216-07-7415A | | |
| 17. INFORMANT ADDRESS 8807 Alnwick Rd. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 2019 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HODGKINS DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 23,</u> 19 <u>82</u> , to <u>JULY 31</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY 31,</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Steve Nelson | | | | 22c. DATE SIGNED 7/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVE NELSON M.D. | | | | 22e. ADDRESS 100 N. BROADWAY BALTO. MD. 21231 CHURCH HOSPITAL CORPORATION | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | |
| 23d. LOCATION CITY OR TOWN Baltimore | | 23e. COUNTY Md. | | 23f. STATE | |
| 24. FUNERAL HOME Schimmonek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | 25. DATE REC'D BY REGISTRAR AUG - 3 1982 | | |

Page 3
death



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, a medical examiner must be notified and a medical examination must be made.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST Zoila C. Arias | | | | | MONTH DAY YEAR 07 11 82 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Female | | | | | Hispanic | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR Feb. 24, 1940 | | | | | 42 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| Ecuador | | | | | Ecuador | | | | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| | | | | | Baltimore | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| Baltimore | | | | | Johns Hopkins Hospital | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Housewife | | | | | | | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | | | |
| Ecuador | | | | | Quito | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Jorge Idrobo | | | | | FIRST MIDDLE LAST Isabel Gonzalez | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| no | | | | | none | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Mr. Gerardo Arias | | | | | Same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 2030 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 5 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (4) (this hospital) attended the deceased from June 18, 1982 , to July 11, 1982 , that (4) (we) lost saw the deceased alive on July 11, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Michael Schindler | | | | | | DEGREE MD | | 22c. DATE SIGNED 7/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHINDLER MD | | | | | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | July 16, 1982 | | Parque de Recuerdo | | Quito Ecuador | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 12 1982 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Frances Jan Netheren | | | |

BP

4/6

Item 11 per phone 7/26/82 dad

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 3 2 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CASSIE Annstead

2a. DATE OF DEATH MONTH DAY YEAR 7 8 82 10 38 AM

2b. HOUR

3. SEX female

4. RACE Black

5. DATE OF BIRTH MONTH DAY YEAR 8-10-16

6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD

10. CITY OR TOWN OF DEATH City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Baltimore

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 2534 W. Mosher St

14. FATHER'S NAME FIRST MIDDLE LAST Moses Harper

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Ross

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no

16b. SOCIAL SECURITY NO. 220141348

17. INFORMANT ADDRESS Thelma Baker 2534 W. Mosher St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLISM
1541
DUE TO, OR AS A CONSEQUENCE OF (b) RHABDOMYOSARCOMA OF RECTUM months
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that (I) (this hospital) attended the deceased from 6/18 19 82 to 7/8 19 82, that (I) (we) last saw the deceased alive on 7/8 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE DEGREE 22b. DATE SIGNED 7/8/82

22c. PHYSICIAN'S NAME (TYPE OR PRINT) 22d. ADDRESS

Herbert A. Kusiher M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

HERBERT A. KUSIHER LUTHERAN HOSPITAL OF MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7/13/82 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. 23d. LOCATION Barto. A.A. COUNTY Md. STATE

24. FUNERAL DIRECTOR Chas. A. Rice FSPA 1300 Eutaw Pl 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUL 15 1982 Frances Jean Nathan

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|--|---|---------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernard Arnold | | | 2a. DATE OF DEATH MONTH DAY YEAR July 9, 1982 | | 2b. HOUR 12:15a | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct 5, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) painter | | 12b. KIND OF BUSINESS OR INDUSTRY construction | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Howard 13c. CITY OR TOWN Laurel | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 10406 Scaggsville Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel Arnold | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Shepherd | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) yes 16b. SOCIAL SECURITY # (IF YES, GIVE WAR OR DATES) 1917-19 218 19 2655 | | | | 17. INFORMANT ADDRESS Mabel Arnold same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1952 IMMEDIATE CAUSE (a) Cachexia | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One Month | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Possible Intra-abdominal Malignancy | | | | | | Two Months | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from June 9 , 19 82 , to July 9 , 19 82 , that (X) (we) lost saw the deceased alive on July 9 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kuo-Liang Huang M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kuo-Liang Huang, M.D. | | | | 22e. ADDRESS C/O Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Donaldson Funeral Home, Laurel, Md | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR SIGNATURE James J. [Signature] | |

MEDICAL CERTIFICATION

35
18
35
130
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified by law.)

6



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 3 | 2 | 3 | | | |
|---|--|--|--|--|---|---|---|--|---|--|---|---|---|---|---|---|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Joseph Thomas Aro</i> | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7-16-82</i> 16 82 4:50 AM | | | | | | | | | |
| 1. SEX <i>Male</i> | | | 4. RACE <i>Caucasian</i> | | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 15 1896</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 73 HRS HOURS MIN. | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i> | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i> | | | | | | |
| 13a. STATE <i>Md.</i> | | | | | | | | | | 13b. COUNTY <i>-</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>4824 Orville Ave.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Albert Aro</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie -</i> | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | | | 16b. SOCIAL SECURITY NO. <i>217-03-7811</i> | | | | | 17. INFORMANT ADDRESS <i>Earl Aro (son) 1714 Weston Ave.</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest.</i> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <i>pneumonia, probable.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Dementia, chronic fibrillation, no pneumonia</i> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/25 19 82</i> | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/25</i> , 19 <i>82</i> , to <i>7/16</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>7/16</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Patricia J. Coon</i> | | | | | | | | | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>7/16/82</i> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia J. Coon</i> | | | | | | | | | | 22e. ADDRESS <i>Beth Hospital</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | | 23b. DATE <i>7/19/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i> | | | | | 23d. LOCATION CITY OR TOWN <i>Baltimore</i> | | COUNTY STATE <i>Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Schimunek Funeral Home, Inc.</i> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 20 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Thos. J. [Signature]</i> | | | | | | | |
| 3331 Brehms Lane, Balto. Md. 21213 | | | | | | | | | | | | | | | | | | | |



2025 JUL 11 11:11 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 2 4 | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| MICHAEL ARPAD | | | | JULY 19, 1982 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| MALE | | WHITE | | AUG 14, 1918 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| HUNGARY | | U. S. A. | | 62 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE | | JOHNS HOPKINS HOSPITAL | | BALTIMORE CITY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | |
| SELF EMPLOYED | | ANTIQUES | | 3303 O. ST. N.W. 20007 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13b. INSIDE CITY LIMITS? | |
| UNKNOWN | | UNKNOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 577-44-2863 | | VIVIAN ARPAD, WIFE 3303 O. ST. N.W. WASH DC | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| 0384 IMMEDIATE CAUSE (a) <u>Intrapulmonary hemorrhage</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>diffuse intravascular coagulation</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>gram negative sepsis</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART 1 is) | | | | | |
| <u>Acute Hairy cell leukemia - Aplasia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6-13-1982, to 7/19 1982, that (1) (we) lost saw the deceased alive on 7/19 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| LUIS F. GIMENEZ | | MD | | 7/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| LUIS F. GIMENEZ | | Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| CREMATION | | JULY 22, 82 | | CEDAR HILL CREMATORY | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 24c. DATE OF DEATH | |
| R&R FUNERAL SERVICES | | 3520 CONN. AVE. N.W. WASHINGTON, D.C. 20008 | | JUL 23 1982 | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED: DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

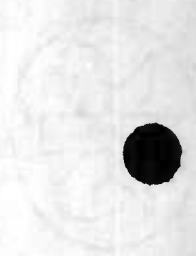
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17325 | |
|--|--------------|--|--|---|--|--|---------------------------------|--|------------------|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) CLARENCE L. HARRISON | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-4-82 | | 2b. HOUR 5:36 AM | | | |
| 3. SEX male | 4. RACE Col. | 5. DATE OF BIRTH MONTH DAY YEAR 7-18-24 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 57 YRS. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 7-4-82 | | 2d. HOUR 5:36 AM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3332 Mondawmin Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Gov. | | | |
| 13a. STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3332 Mondawmin Ave. | | | |
| 14. FATHER'S NAME FRANK | | 15. MOTHER'S MAIDEN NAME Lula | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) WW II | | 16b. SOCIAL SECURITY NO. 267-20-2915 | | 16c. INFORMANT Mrs. Ruthadell Harrison | | | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED 7-4-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-8-82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 12 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 1 7 3 2 6 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Brenard Lynn ASHBROOK, Jr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-6-82 | | 2b. HOUR 7:27 PM | | | |
| 3. SEX male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 6 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 15 yrs. | | IF UNDER 1 YEAR MONTHS DAYS 15 3 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Brenard Lynn Ashbrook | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Robin Kay Ragland | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. NA | | 17. INFORMANT ADDRESS Robin Kay Ragland, Hagerstown, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7689 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PERINATAL ASPHYXIA DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 16 HOURS | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a DISSEMINATED INTRAVASCULAR COAGULATION | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 6 19 82 , to JULY 6 19 82 , that (I) (we) last saw the deceased alive on JULY 6 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Michael F. Schmale | | | | | DEGREE | | 22c. DATE SIGNED 7/6/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL F. SCHMALE | | | | | 22e. ADDRESS 301 ST PAUL ST. BALTO., MD 21202 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE July 12, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 12 1982 | | | | | |



MAILED

NOV 10 1903

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAILED" and "NOV 10 1903" are visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|------------------|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth A. Babylon | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7 29 19 82 | | | 2b. HOUR M 11:40 | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 7, 1916 | 6. AGE IN YEARS (LAST BIRTHDAY) 65 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7 29 19 82 | 2d. HOUR M 11:40 | | | |
| 1a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 1d. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1109 Woodheights Avenue | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) at home | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1109 Woodheights Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. H. Horton | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise May Armstrong | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 215 12 1002 | | 17. INFORMANT ADDRESS Joyce Fidler same | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | | TITLE (SPECIFY) M.D. Deputy Chief Medical Examiner | | | | | DATE SIGNED 7/30/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Eldersburg Carroll Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Burgee Funeral Home 3631 Falls Road 21211 | | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR'S SIGNATURE James E. Nathan | | |

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

Revised Date Dec. 2, 1912

Revised

at home

1100 Woodlawn Avenue

XX

Alitoxo

J. H. Norton

Louise May Norton

212 12 1912 Love Taylor

Revised Date Dec. 2, 1912

Revised

2/2/2

Alitoxo

Louise May Norton

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial certificate. Then please remove carbon copies. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR MAYNARD BACON | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1982 | | | 2b. HOUR 1:07PM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC 7 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DIST. OF COL. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOCTOR - M.D. | | 12b. KIND OF BUSINESS OR INDUSTRY RETIRED | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN PARKVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALLAN T. BACON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE MAYNARD | | | 16. ADDRESS 2810 TAYLOR AVE. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 17. INFORMANT FAMILY RECORDS | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4414 Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Streptococcus pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ischemic Colitis following aortic aneurysm repair | | | | | | | | | |
| 19a. DATE OF OPERATION 6/30/82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal aortic aneurysm | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 P.M. 7 31 1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 28, 1982, to July 31, 1982, that (I) (we) last saw the deceased alive on July 31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE David W. Crist | | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David W. Crist | | | 22e. ADDRESS 528 A North Bond Balt. md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8/4/1982 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. COUNTY MD. | | |
| 24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL | | | ADDRESS 8800 HARFORD RD | | 25a. DATE REC'D. BY REGISTRAR AUG-5-1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | |

DATE RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MAURICE BADNER | | | 2a. DATE OF DEATH MONTH 7 DAY 10 YEAR 82 | | | 2b. HOUR 3 P | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH FEBRUARY DAY 7 YEAR 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS 84 DAYS 84 HOURS 84 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY UPHOLSTER | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN PIKESVILLE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1630 Reisterstown Rd | |
| 14. FATHER'S NAME FIRST ISAAC MIDDLE BADNER LAST BADNER | | | | 15. MOTHER'S MAIDEN NAME FIRST KATE MIDDLE RAPPOPORT LAST RAPPOPORT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI | | 17. INFORMANT ADDRESS APT. 2-B (21208) MISS DORIS WILLIAMS 7213 VALLEY COUNTRY CT. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 Cardiac & Respiratory Failure IMMEDIATE CAUSE (a) Cardiac & Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Heart Disease & Failure DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive Lung Disease | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years 4 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral Monitors | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 22, 1982 to July 10, 1982 , that (I) (we) last saw the deceased alive on July 10, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Manuel Levin MD | | | | DEGREE MD ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN M.D. | | | | 22e. ADDRESS 6101 PK HTS AVE BALTO MD 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 12, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH CEM. | | 23d. LOCATION CITY OR TOWN ROSEDALE COUNTY BALTIMORE STATE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS INC ADDRESS 6010 REISTERSTOWN RD, BALTIMORE, MARYLAND 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 3 0

REG. NO.

| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Rose</u> MIDDLE <u>Baer</u> LAST <u>Baer</u> | | 2a. DATE OF DEATH MONTH <u>7</u> DAY <u>5</u> YEAR <u>82</u> | | 2b. HOUR <u>7¹⁰</u> A.M. | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>2</u> DAY <u>22</u> YEAR <u>97</u> | |
| 6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS <u>XXX</u> DAYS <u>XXX</u> | | 7. IF UNDER 24 HRS. HOURS <u>XXX</u> MIN. <u>XXX</u> | |
| 7a. BIRTHPLACE COUNTRY <u>Latvia</u> STATE OR FOREIGN <u>Latvia</u> | | 7b. CITIZEN OF WHAT COUNTRY <u>Latvia</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto. City</u> MD. | | 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>LEVINDALE HEBREW HOME</u> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>OPERATOR</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>MEN'S CLOTHING</u> | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13b. COUNTY <u>MARYLAND</u> | | 13c. CITY OR TOWN <u>BALTIMORE</u> | | 13d. STREET ADDRESS <u>6424 ELRAY DR. #21209</u> | |
| 14. FATHER'S NAME FIRST <u>WOLF</u> MIDDLE <u>BAER</u> LAST <u>BAER</u> | | 15. MOTHER'S MAIDEN NAME FIRST <u>IDA</u> MIDDLE <u>UNKNOWN</u> LAST <u>UNKNOWN</u> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | |
| 16b. SOCIAL SECURITY NO. <u>216-05-3329</u> | | 17. INFORMANT <u>ABE WEISS</u> | | ADDRESS <u>6634 CHIPPEWA DR. BALTO., MD 21209</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEPSIS</u> <u>4379</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>URINARY TRACT INFECTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBROVASCULAR DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>10 DAYS</u> <u>3 YRS.</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION <u>7/5</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>URINARY TRACT INFECTION</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>3-11</u> , 19 <u>77</u> , to <u>7/5</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>7/5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>Charles K. Reister</u> | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>7/5/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHARLES K. REISTER</u> | | 22e. ADDRESS <u>LEVINDALE HOSP.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>JULY 6, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>BETH JACOB ANSHE VESHEAR</u> | |
| 23d. LOCATION CITY <u>ROSEDALE</u> BALTO. MD <u>MD</u> | | 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD. BALTO., MD 21215</u> | | | |
| 25a. DATE REC'D. BY REGISTRAR <u>JUL 8 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | |

2



[Faint, mostly illegible handwritten text and markings covering the majority of the page. Some words like "STATION" and "RECEIVED" are faintly visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|-----------------------------------|--|--|--|---------------------------------------|--|-------------------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Eileen | | | | | | Bahur | | 7 | | 28 | | 19 | | 82 | | 3:40 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | Cauc. | 4 4 1939 | | 43 | | YRS. | | | | 7 | | 28 | | 19 | | 82 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. MARRIED | | NEVER MARRIED | | 10. DIVORCED | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | U.S.A. | | X | | | | | | Baltimore City | | | | | | | |
| 12. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | Good Samaritan Hospital | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Md. | | | | Baltimore | | YES X NO | | 19 N. Streeper St. | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | |
| Robert | | J. | | Demski | | Bertha | | | | Siekierski | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 213-34-8192 | | Robert Demski | | 6604 Danville Ave. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 4254 | | | | Cardiomyopathy | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO X | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| NOT WHILE AT WORK | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural cause X | | Accident | | Suicide | | Homicide | | Undetermined manner | | and in my opinion | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | M.D. Deputy Chief | | MEDICAL EXAMINER | | DATE SIGNED | | 7-29-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Thomas D. Smith, M.D. | | ADDRESS | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | |
| Burial | | 7/31/82 | | Holly Hills Cem. | | Baltimore | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| B. Dabrowski & Son | | | | 2818 E. Baltimore St. | | AUG 4 1982 | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BABY BOY " Kyle " BAILEY | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1982 | | | 2b. HOUR 06:30AM | | | | |
| 3 SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR July 28, 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 0 30 | | IF UNDER 1 YEAR IF UNDER 74 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | | 12b. KIND OF BUSINESS OR INDUSTRY N/A | | |
| 13a. STATE Maryland | | | | | 13b. CITY OR TOWN Talbot | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS P.O. Box 362 21662 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip H. Bailey Jr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glenda L. Gautier | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Philip H. Bailey Jr. Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7651 IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) - PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION NONE | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/28, 19 82, to 7/28, 19 82, that (I) (we) lost saw the deceased alive on 7/28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE James Anastasi | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/29 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Anastasi | | | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD. | | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home | | | | | ADDRESS Catonsville, Md. | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 - 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) NOVELLA | | FIRST MIDDLE LAST BAILEY | | 2a. DATE OF DEATH MONTH DAY YEAR 07-09-82 | | 2b. HOUR 7:05 AM | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10 14 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PROVIDENT HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2106 ASHBURTON ST. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GONZIE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMMIE YOUNG | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS LESTER BAILEY 2106 ASHBURTON ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4275 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) GENERALISED FAILURE OF HEMODIASIS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 2ND, 1982 , to JULY 9TH, 1982 , that (I) (we) last saw the deceased alive on JULY 9TH, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE BEN MAGNUS-LAWSON MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEN MAGNUS-LAWSON MD | | 22e. ADDRESS PROVIDENT HOSPITAL BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUSUS MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | ADDRESS 1721 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR JUL 12 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. Walker | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove card papers, Pages 1 and 2, should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.DHMH 16 50M 1/BI
(VRA 15, 4)FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stella - Bailey | | | 2a. DATE OF DEATH MONTH DAY YEAR July 10, 1982 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hamilton Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. CITY OR TOWN Cockeysville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 1108 Dulaney Gate Circle | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Michael Idzebeski | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - - | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 212-03-5804D | | 17. INFORMANT ADDRESS Mrs. Eleanor Petty same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) arteriosclerotic cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (b) vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) many years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 73 , to 7/10 , 19 82 , that (I) (we) last saw the deceased alive on 6/19 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Hans Koetter | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hans Koetter MD | | 22e. ADDRESS 7600 Osler Drive Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto. Md. | | 25a. DATE RECEIVED BY REGISTRAR JUL 13 1982 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland | | 25b. REGISTRAR'S SIGNATURE James Van Natten | | | |

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COTTON FIBER

11/13/19

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Moses

Baker, Jr.

2a. DATE KNOWN OF DEATH ☒ MONTH ☐ DAY ☐ YEAR ☐ HOUR ☐ MIN

7 8 1982

3. SEX
Male4. RACE
Black5. DAY OF BIRTH MONTH YEAR
7 2 236. AGE (IN YEARS) (LAST BIRTHDAY)
59 YRS.

IF UNDER 1 YR. MONTHS DAYS

IF UNDER 24 HRS. HOURS MIN

2c. DATE PRONOUNCED DEAD
7 8 19822d. HOUR
6:12A7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C.7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD.10. CITY OR TOWN OF DEATH
Baltimore11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Patterson & Brighton Aves.12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
12b. KIND OF BUSINESS OR INDUSTRYUSUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md.13b. COUNTY
Balt13c. CITY OR TOWN
Balto.13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS
3664 Forest Hill Rd.14. FATHER'S NAME
FIRST MIDDLE LAST
Moses

Baker, Sr.

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma

Graham

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes

16b. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS
T. Ruth Baker 3664 Forest Hill Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Thomas D. Smith, M.D.

TITLE (SPECIFY)

Deputy Chief MEDICAL EXAMINER

DATE SIGNED 7/8/82

EXAMINER'S NAME
(TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial23b. DATE
7/13/8223c. NAME OF CEMETERY OR CREMATORY
Md. Nt. Me. Pk.23d. LOCATION
CITY OR TOWN COUNTY STATE
Laurel, Md.

24. FUNERAL DIRECTOR

NAME
Wm C March F/HADDRESS
1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR

JUL 9 1982

25b. REGISTRAR'S SIGNATURE

Thomas D. Smith

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 3 3 6 | | | |
|---|--|---|--|---|--|---|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM HARVEY BAKER | | | | 2b. DATE OF DEATH MONTH DAY YEAR 7 15 82 | | | |
| 3. SEX Male | | | | 2b. HOUR 5:07 PM | | | |
| 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 13, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truckdriver | | 12b. KIND OF BUSINESS OR INDUSTRY Auto Parts | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Pasadena | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harvey William | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alvilda ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 217-26-0542 | | 17. INFORMANT ADDRESS Evelyn J. Baker, same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) this hospital attended the deceased from July 9, 1982, to July 15, 1982, that (X) (we) lost saw the deceased alive on July 15, 1982, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (K) (we) did (X) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DEGREE Beverly Kelsey MD | | | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beverly Kelsey MD | |
| 22e. ADDRESS VAMC, Baltimore, Maryland 21218 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Vets. Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Anne Arundel Md. | |
| 24. FUNERAL DIRECTOR McCully F. H. Mountain & Tice Neck Rd. 21122 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE Anne Arundel | | | | | | | |

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FOR
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REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 7 3 3 7

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOUISE Victoria BALL | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/23/82 | | 2b. HOUR 6:30 PM |
| 3. SEX Female | 4. RACE CACASION | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) 33 | |
| 7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) N. J. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. Hos p.s | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. | | | 13b. COUNTY Cecil | 13c. CITY OR TOWN Conowingo | 13d. INSIDE CITY LIMITS? X NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sylvester Hannah | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bonnie May Messer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-52-5810 | | 17. INFORMANT NAME ADDRESS Wilmer A. Ball (Same as above) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4424 IMMEDIATE CAUSE (a) Cerebrovascular Accident | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hrs |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Suspected Aneurysm rupture DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 82 , to 7/23 , 19 82 , that (I) (we) lost saw the deceased alive on 7/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph L. Goode | | DEGREE M.D. | | 22c. DATE SIGNED 7/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH L. GOODES | | 22e. ADDRESS 22 S. Green St, Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-27-82 | 23c. NAME OF CEMETERY OR CREMATORY West Notting ham | | 23d. LOCATION CITY OR TOWN COUNTY STATE Colomac Cecil Md. | |
| 24. FUNERAL DIRECTOR NAME Richard L. Goode | | ADDRESS Rising Sun, Md. | | 25a. DATE REG. BY JUL 29 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

James
Victoria Ball

Excursion Oct 7, 1883
Baltimore City

Mr. J. M. Ball
The Ball Club

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 3 3 8 | |
|--|--|---|--|---|--|--|--|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST PHILIP A. BALLARD Sr. | | | 2a. DATE OF DEATH | | MONTH DAY YEAR 7 7 82 | 2b. HOUR 2:10 A M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 6 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY W.P. Ballard Co | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 20 S. Beaumont Avenue 21228 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Ballard | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Reid | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2 | | | | 16b. SOCIAL SECURITY NO. 57B-03-3147 | | 17. INFORMANT ADDRESS Mrs. Philip A. Ballard, Sr. Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4120 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) OLD MYOCARDIAL INFARCTIONS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal Failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 7 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1982, to July 7, 1982, that (I) (we) last saw the deceased alive on July 7, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Carlos G. Govantes | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLOS G. GOVANTES | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Witzke P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE Honora Van Natten | | | |
| 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | | | |

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1. STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Adele B. BALLMAN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 22 1982 | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 14 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7b. HOUR 6:34 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green N. H. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor | | 12b. KIND OF BUSINESS OR INDUSTRY College | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1111 Argonne Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francis H. Ballman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes M. Boehl | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-36-6864 | | 17. INFORMANT ADDRESS Joseph W. Miller Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral A-S DUE TO, OR AS A CONSEQUENCE OF (c) 4-yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/11 to 7/22/82 and that in (my) 7/22/82 opinion death occurred on the date and hour and from the causes stated above. (I did not and do not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE Norman R. Freeman Jr. M.D. DEGREE | | | | | 22c. DATE SIGNED 7/23/82 | | | 22d. ADDRESS 1111 23 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co., Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR 7/23/82 REGISTRAR'S SIGNATURE Santhien | | | | | |

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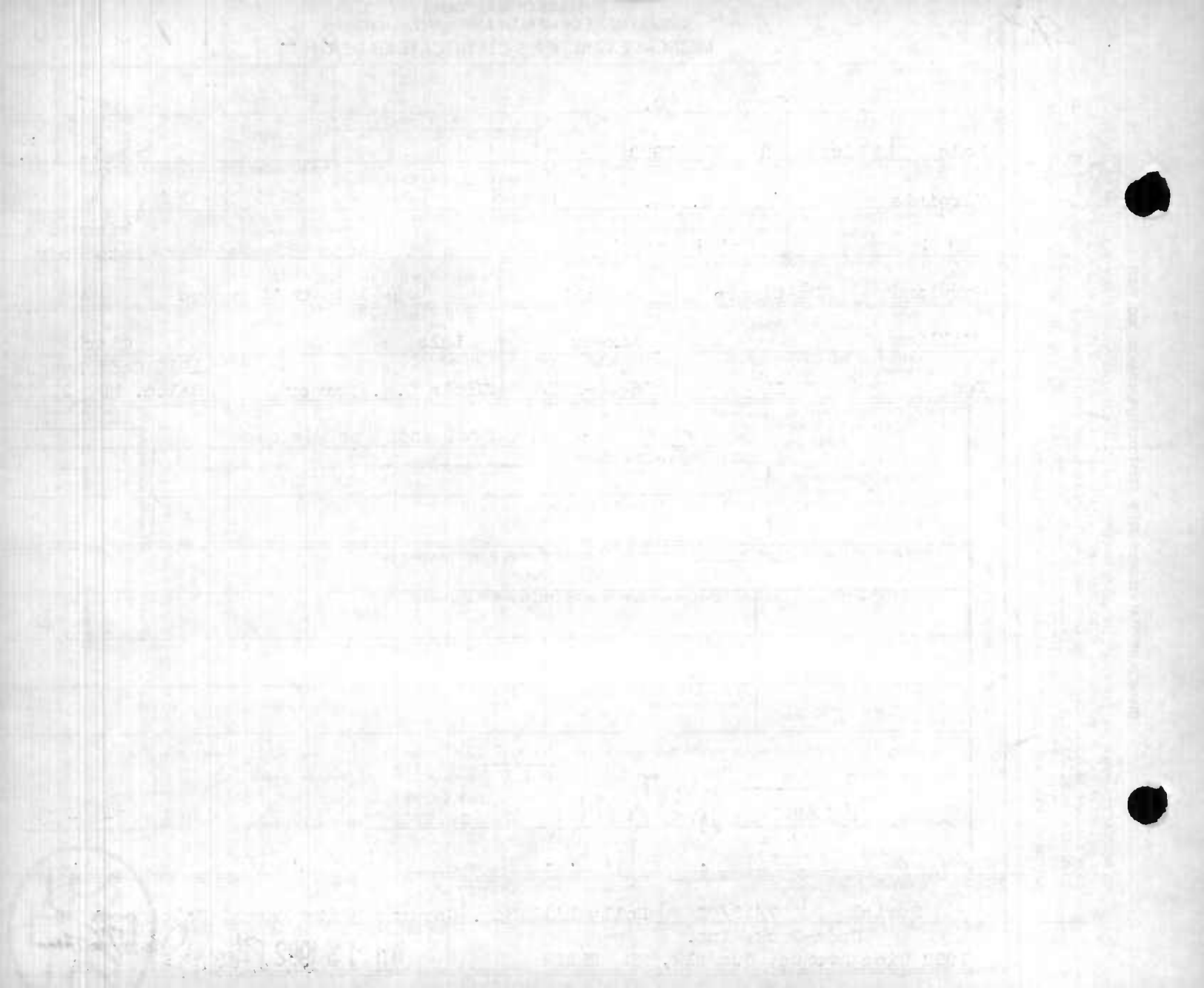
-1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO

1 7 3 4 0

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|-------------------|--|---|--|------------------|--|---|--|-------|--|---|--|-----------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | |
| James | | O. | | Barger | | | | 7 | | 9 | | 1982 | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | | | | |
| Male | | White | | 2 27 1923 | | 59 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 7 9 1982 | | 6:24 P.M. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | | | U.S.A. | | | | | | | | Baltimore City, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS | | | | | | | | | | | |
| Baltimore | | | | Baltimore City Hospital | | | | Auto Body Painter | | | | Auto Body | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | | | Baltimore | | | | Dundalk | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 1916 Codd Avenue | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | |
| William Barger | | | | Lula Clark | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN?) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | |
| Yes | | | | WW II | | | | 226-28-2678 | | | | Viola C.M. Barger | | | | 1916 Codd Avenue Balto. MD 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | | | | | | | | | DATE SIGNED | | | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant MEDICAL EXAMINER | | | | | | | | | | | | 7-10-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | | | 7/13/82 | | | | Holly Hill Mem. Gardens | | | | White Marsh, Baltimore, MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Duda-Ruck, Inc. | | | | JUL 13 1982 | | | | Frances Van Natten | | | | | | | | | | | | | | | |
| 7922 Wise Avenue, Dundalk, MD 21222 | | | | | | | | | | | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

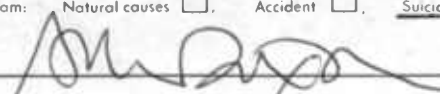

BP

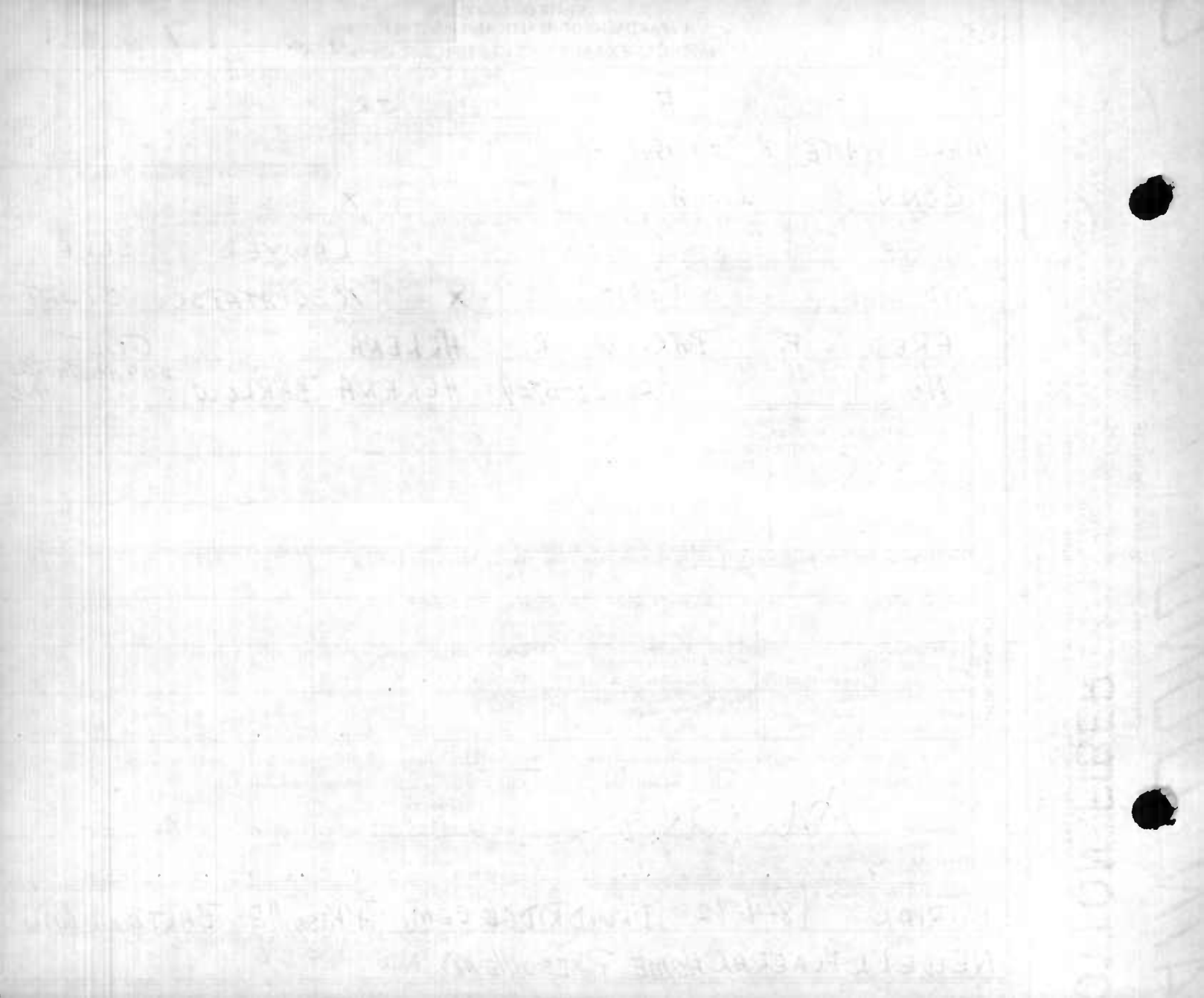
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|---------------|---|--|---|--|---|--------------------|--|--|---|--|--|--------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST FRED | | | MIDDLE F. | | | LAST BARLOW JR. | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 30 19 82 | | | 2b. HOUR M 1:05 | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8 27 1944 | | 6. AGE (IN YEARS) LAST BIRTHDAY 40 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD 7 31 19 82 | | | 2d. HOUR P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1030 Patapsco Court | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER | | | | 12b. KIND OF BUSINESS OR INDUSTRY SELF | | | | | |
| 13a. STATE MD. | | | | | | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1030 PATAPSCO COURT | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRED F. BARLOW SR. | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELENA OBST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 220-38-5724 | | | | 17. INFORMANT HELENA BARLOW | | | | ADDRESS 209 HAWTHORNE AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hanging</u> 9530 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7-30- 19 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hanged self. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1030 Patapsco Ct. Balto. MD. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 8-1-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | | | 23b. DATE 8-4-82 | | 23c. NAME OF CEMETERY OR CREMATORY DRUIDRIDGE CEM. | | | | 23d. LOCATION OR TOWN COUNTY STATE Pikesville BALTIMORE MD | | | | | | | |
| 24. FUNERAL DIRECTOR NAME NEWELL FUNERAL HOME | | | | ADDRESS Pikesville MD | | | | 25a. DATE REC'D. BY REGISTRAR AUG 5 1982 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



10-15-58
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the attending physician and completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 2 1 7 3 4 2

1. FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM E. BARNES Sr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1982 | | 2b. HOUR 6:05p | |
| 3. SEX male | | 4. RACE Col. | | 5. DATE OF BIRTH MONTH DAY YEAR 11 - 9 - 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT AVAILABLE, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) 13b. STATE Maryland | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1802 Durham St | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William E. Barnes Sr. | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Addie Simms | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. 213-32-8830 | | 17. INFORMANT ADDRESS Mr. William Barnes Sr. 2647 Edmondson Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF: (b) probable anterior myocardial infarct DUE TO, OR AS A CONSEQUENCE OF: (c) probable coronary artery dx. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased John Barnes on 7/28 , 19 82 , that (I) (we) lost saw the deceased alive on 7/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Niles | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John L. Niles | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-2-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | ADDRESS 2222 W. North Ave. | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR'S SIGNATURE Phyllis J. ... | |

2005 COTTON FIBRE

EMULSION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

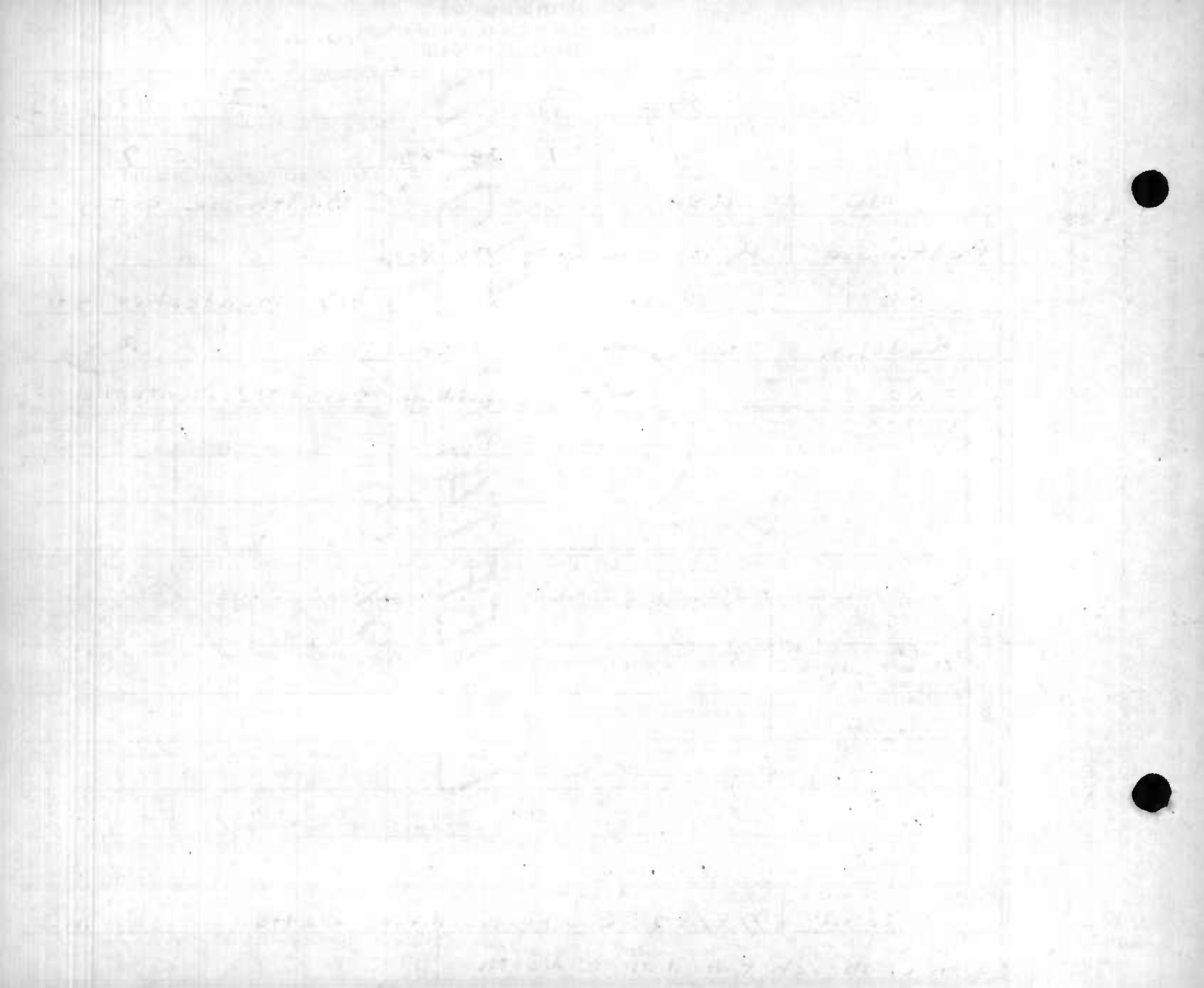
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 4 3

| | | | |
|--|---|--|---|
| FOR 1 - STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST Stanley BB A Bass | | MONTH DAY YEAR HOUR 7 4 82 12:12 AM | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| male | black | MONTH DAY YEAR 1 28 82 | IF UNDER 1 YEAR MONTHS DAYS 5 7 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| MO | USA | | Baltimore City MD |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | Baltimore City Hosp. | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| MO | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | 13e. STREET ADDRESS | |
| Rudolph Stanley Clark | Geraldine Bass | 917 Montpelier St. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17. INFORMANT | ADDRESS |
| NO | N/A | Geraldine Bass | 917 Montpelier St. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7798 Cardiac Arrest - etiology undetermined | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Prematurity, Chronic Lung Disease, Cardiac Disease - suspect VSD | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 28, 19 82, to July 4, 19 82, that (I) (we) lost saw the deceased alive on July 3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Jennifer L. Catchings | DEGREE MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 7/4/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jennifer L. Catchings | 22e. ADDRESS 4940 Eastern Ave Balto, Md 21224 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/8/82 | 23c. NAME OF CEMETERY OR CREMATORY Eastview mem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 4 4

| | | | | | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Ann C Becker | | 7/24/82 | | 9:40 AM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Oct. 31 1920 | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md | 13b. CITY OR TOWN Balto | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS 403 Overbrook Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ambrose Foreman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Willson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 217 12 1087 | | 17. INFORMANT ADDRESS Philip V. Becker Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4960 IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1 82, 19 to July 24 19 82, that (I) (we) last saw the deceased alive on July 24 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Honorato L. Borja | | DEGREE | | 22c. DATE SIGNED 7/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HONORATO L. BORJA, MD. | | 22e. ADDRESS GOOD SAMARITAN HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/27/ 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Hpmc | | 25a. DATE REC'D BY REGISTRAR JUL 28 1982 | | 25b. SIGNATURE | |

MEDICAL CERTIFICATION

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 4 5

1. FOR
STATE
REGISTRAR

REG. NO.

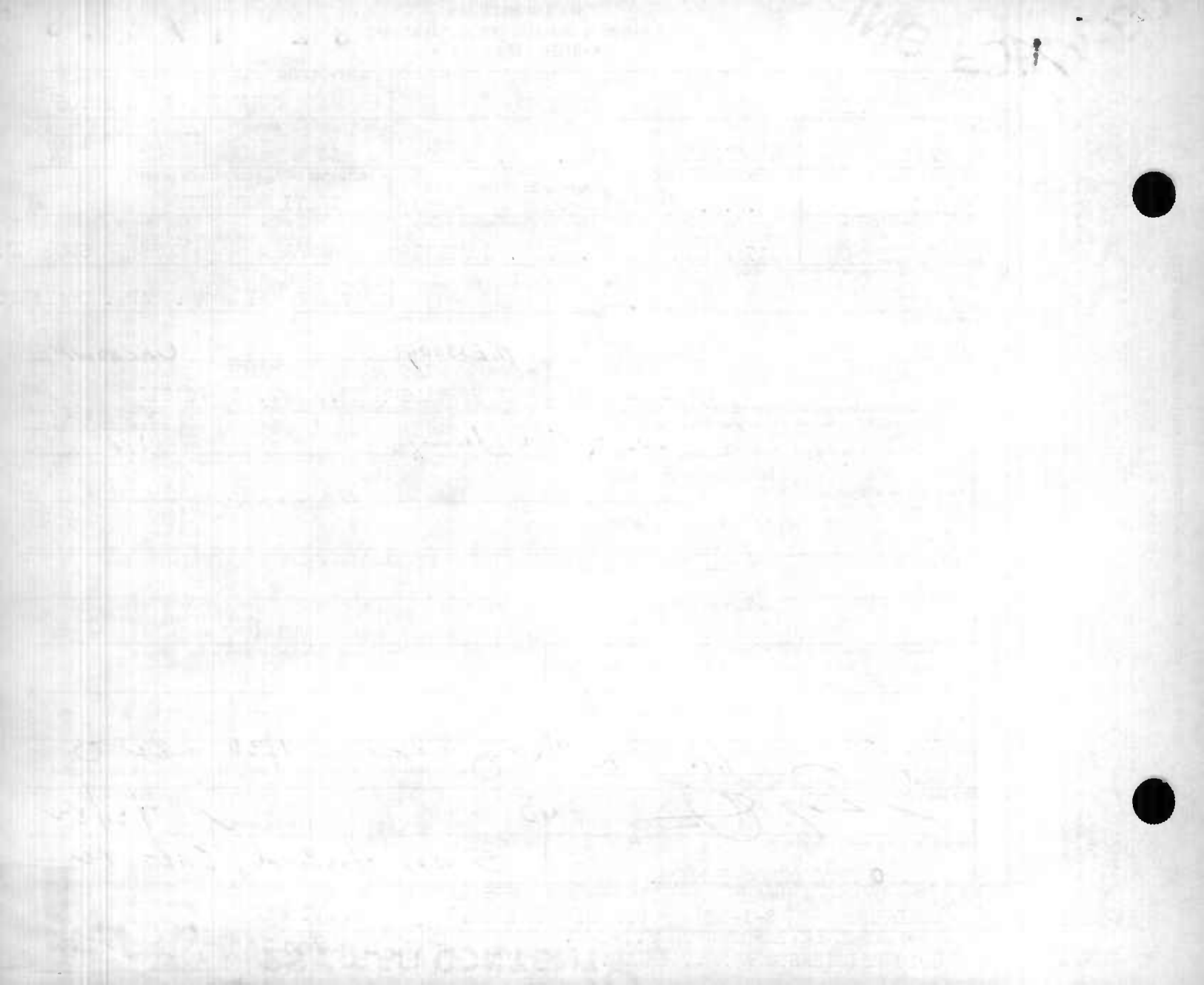
| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST BECRAFT | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 1 82 | | 2b. HOUR 7 A.M. |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4-17-1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) COUNTY Balto. Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FORM MOST OF WORKING LIFE) Home Maker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Md. | 13b. COUNTY | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 507 E. 35th Street -21218 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George H. January | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Ellen Brooks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-14-7519 | 17. INFORMANT ADDRESS Mr. James G. Becraft - 507 E. 35th St. -21218 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Insufficiency 5738 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 7, 19 82 to JULY 1, 19 82, that (I) (we) last saw the deceased alive on JULY 1, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Carl Sperlung MD | | DEGREE MD | | 22c. DATE SIGNED 7/1/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLUNG, M.D. | | 22e. ADDRESS 201 E UNIVERSITY PKWY BALTO 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-3-82 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Md. | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 | | 25a. DATE REC'D. BY REGISTRAR JUL 2 1982 | | 25b. REGISTRAR'S SIGNATURE Theresa Jan Warren | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 1 7 3 4 6 | |
|--|---------------------|---|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) JAIME BENHAMOU | | | 2a DATE OF DEATH JULY 30, 1982 | | 2b HOUR 10:05 ^P M | |
| 3 SEX MALE | 4 RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 6, 1929 | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MOROCCO | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3917 FORDLEIGH RD., APT. C #21215 | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHOEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY COBBLER SHOE CO. |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND | | | 13b COUNTY BALTIMORE | 13c CITY OR TOWN BALTIMORE | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST JACOB BENHAMOU | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MESSODY UNKNOWAN | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 219-86-6903 | | 17 INFORMANT MISS ANNIE BENHAMOU 3917 FORDLEIGH RD., APT. C #21215 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of the lung.</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>7/14</u> 19 <u>82</u> , to <u>7/30</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE <u>MODESTO ORDOQUI</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c DATE SIGNED 7/31/82 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) MODESTO ORDOQUI, M.D. | | 22e ADDRESS SINAI HOSPITAL, BALT. MD. | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b DATE 8-1-82 | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD | |
| 24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | 25a DATE REC'D BY REGISTRAR AUG - 3 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|--|
| 1- FOR STATE REGISTRAR | | 7 2 1 7 3 4 7 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Carl William Benner CARL W. BENNER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-31-82 | | | 2b. HOUR 9:10 P.M. | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 3 24 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER | | 12b. KIND OF BUSINESS OR INDUSTRY Private | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTO. | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 188 DUNBARTON RD. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CONRAD BENNER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLGA ERNI | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 220-14-5334 | | 17. INFORMANT ADDRESS Mrs. Carl W. Benner 188 Dumbarton Rd 21212 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) CANCER OF PROSTATE-METASTATIC DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7 , 19 82 , to 7-31 , 19 82 , that (I) (we) lost saw the deceased alive on 7-31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Stephen P. Brutscher | | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7-31-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. BRUTSCHER | | | | 22e. ADDRESS U. OF MARYLAND HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-3-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home | | | | ADDRESS 6500 York Rd 21212 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 5 1982 [Signature] | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Alphonso Bennett | | July 18, 1982 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) |
| Male | Black | 6 MONTH DAY YEAR | 61 YRS. |
| 7a. BIRTHPLACE (COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| S.C. | USA | | Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| Baltimore | Lutheran Hospital | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | 13a. STREET ADDRESS | | 13b. CITY OR TOWN |
| | 1558 Moreland Avenue | | Baltimore |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) |
| | | | Yes |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Patricular fibrillation</u> |
| 248-32-2881 | Mabel A. Bennett 1558 Moreland Ave. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 min 10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u> | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | P.M. 19 | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/73</u> 19 <u>73</u> , to <u>7/18</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED |
| Elijah Saunders, M. D. | M.D. | | 7/28/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| Elijah Saunders, M. D. | 2 Hamill Rd. Ste. 320 Balto., Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 7/23/82 | Md. Veteran Cem. | Crownsville MD |
| 24. FUNERAL DIRECTOR NAME | | 25. DATE RECEIVED BY REGISTRAR'S SIGNATURE | |
| Wm. C. March F/H 1101 E. North Ave. | | JUL 21 1982 Frances Jan Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Handwritten notes, possibly a list or description, including the word "Hypocotyl" and other illegible text.

On the left side of the page, there is a handwritten note that reads "On the left side of the page".

Handwritten notes at the bottom of the page, including the word "Hypocotyl" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|---|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) VERNON BENNETT | | | | | 2a. DATE OF DEATH MONTH 7 DAY 7 YEAR 82 2b. HOUR 6:45 ^M | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 11 DAY 23 YEAR 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 15. KIND OF BUSINESS OR INDUSTRY Laundry | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland 16b. COUNTY Carroll 16c. CITY OR TOWN Sykesville | | | | | 17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 18. STREET ADDRESS 6504 Sykesville Road | | |
| 19. FATHER'S NAME FIRST William MIDDLE Henry LAST Bennett | | | | | 20. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE C. LAST Verna | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII | | | | | 22. SOCIAL SECURITY NO. 214-03-0609 | | 23. INFORMANT Mrs. Anna E. Bennett | | |
| 24. ADDRESS 6504 Sykesville Rd. Sykesville, Md. | | | | | | | | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4241 IMMEDIATE CAUSE (a) Acute Stenotic LEFT Ventricular Failure DUE TO, OR AS A CONSEQUENCE OF (b) Aortic Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure | | | | | | | | | |
| 26. DATE OF OPERATION | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 31. TIME OF INJURY HOUR (A.M. OR P.M.) 6:45 P.M. MONTH 7 DAY 7 YEAR 82 | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 33. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 35. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from July 1, 1982 to July 7, 1982 that (I) (we) last saw the deceased alive on July 7, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 37. SIGNATURE Carlos L. Gouantes | | | | | 38. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 39. DATE SIGNED 7/7/82 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) CARLOS GOUANES | | | | | 41. ADDRESS | | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 43. DATE 7-10-82 | | 44. NAME OF CEMETERY OR CREMATORY Old Oakland Cemetery | | 45. LOCATION CITY OR TOWN Oakland COUNTY Carroll STATE Maryland | | 46. FUNERAL DIRECTOR NAME Haight Funeral Home ADDRESS Sykesville, Md. | |
| 47. DATE REC'D. BY REGISTRAR JUL 8 1982 | | | | | 48. REGISTRAR'S SIGNATURE Thomas Van Natta | | | | |

HAL/4 3 201 92 84

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON-MED DR H. GUARD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by p.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 3 5 0 | |
|--|--|--|--|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANK BENTON Jr | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 17, 1982 | | | 2b. HOUR 3:45A M | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 10, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7. BIRTH PLACE MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 611 N. Linwood Ave | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216-07-1010 | | 17. INFORMANT NAME ADDRESS Irene Benton 611 N. Linwood Ave | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14 , 19 82 , to July 17 , 19 82 , that (I) (we) lost saw the deceased alive on July 17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Mark R Gilbert | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7-17-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK R GILBERT | | | | | 22e. ADDRESS JOHNS HOPKINS Hosp. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City MD. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond L. Kozminski 2500 Shurtl. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 3 5 1
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGELO - BERTUCCI | | 2. DATE OF DEATH MONTH DAY YEAR 7 18 82 | |
| 3. SEX Male | | 2b. HOUR 6:35 P _M | |
| 4. RACE White | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 7 27 11 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 12b. KIND OF BUSINESS OR INDUSTRY Penn Central RR | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218 | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | |
| 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anthony Bertucci | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WW II 437 07 6670 | |
| 17. INFORMANT ADDRESS Anthony Bertucci 900 East 30th St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes one month one month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Renal Failure Hypoxic encephalopathy</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 30, 1982, to July 18, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 18, 1982, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Kevin J. Doyle MD | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin J. Doyle MD | | 22e. ADDRESS VAMC, Baltimore, Maryland 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 22 '82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co. Maryland | |
| 24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | |
| 25b. REGISTRAR'S SIGNATURE James VanNathan | | | |

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1892. It is a message of congratulatory and encouragement to the new Congress, and it is a message of warning to the people of the United States. The President says that the country is in a state of great peril, and that the people must be warned of the dangers that threaten them. He says that the country is in a state of great peril, and that the people must be warned of the dangers that threaten them.

2. The second part of the document is a report of the Secretary of the Interior, dated January 3, 1892. It is a report of the work done by the Department of the Interior during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

3. The third part of the document is a report of the Secretary of the Treasury, dated January 3, 1892. It is a report of the work done by the Department of the Treasury during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

4. The fourth part of the document is a report of the Secretary of the War, dated January 3, 1892. It is a report of the work done by the Department of the War during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

5. The fifth part of the document is a report of the Secretary of the Navy, dated January 3, 1892. It is a report of the work done by the Department of the Navy during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

6. The sixth part of the document is a report of the Secretary of the Post Office and Telegraphs, dated January 3, 1892. It is a report of the work done by the Department of the Post Office and Telegraphs during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

7. The seventh part of the document is a report of the Secretary of the Land Office, dated January 3, 1892. It is a report of the work done by the Department of the Land Office during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

8. The eighth part of the document is a report of the Secretary of the Indian Affairs, dated January 3, 1892. It is a report of the work done by the Department of the Indian Affairs during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

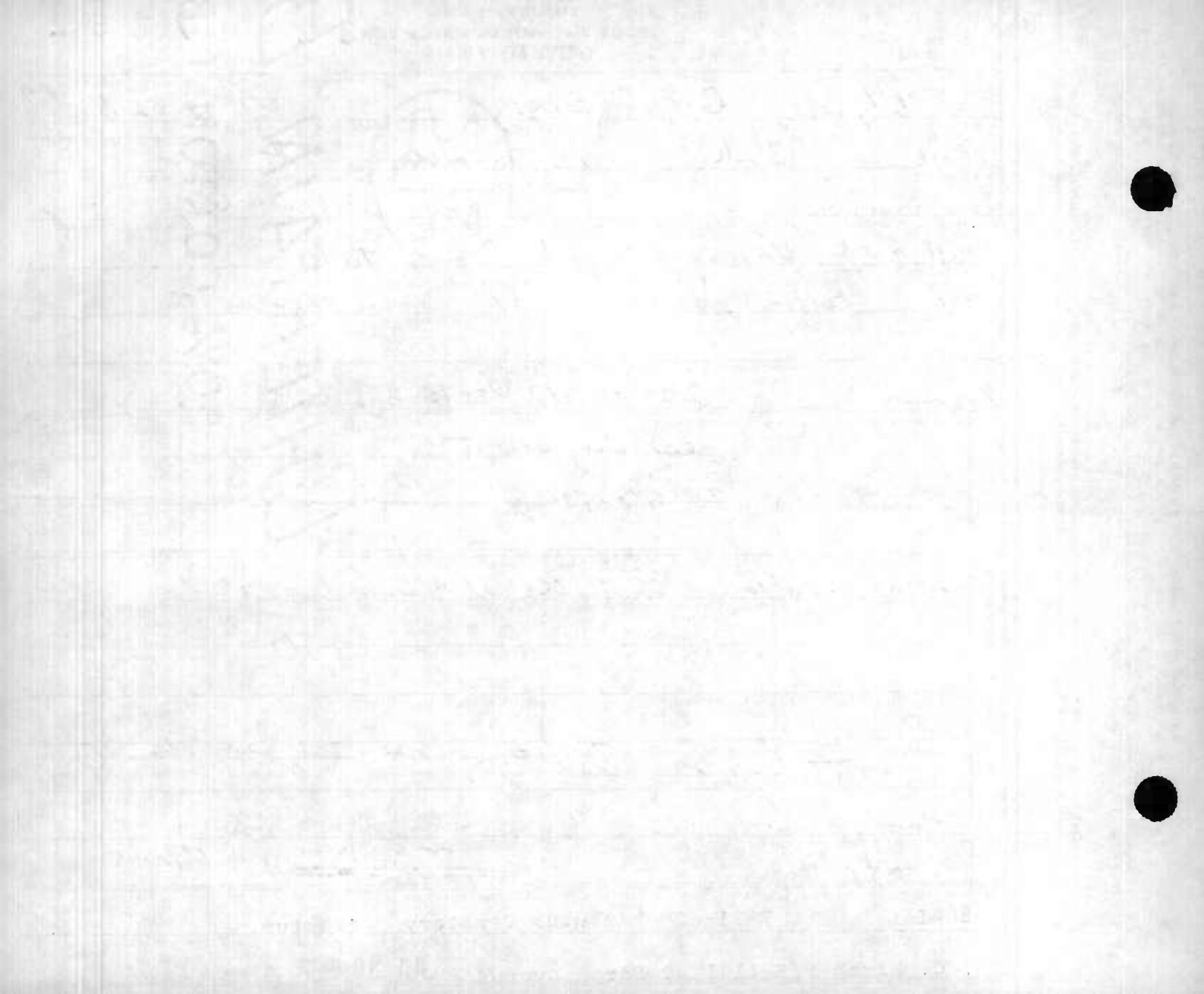
9. The ninth part of the document is a report of the Secretary of the Marine Corps, dated January 3, 1892. It is a report of the work done by the Department of the Marine Corps during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

10. The tenth part of the document is a report of the Secretary of the Army, dated January 3, 1892. It is a report of the work done by the Department of the Army during the year 1891. The report is a long and detailed account of the work of the Department, and it is a report of the progress of the work of the Department.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before removal.)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 3 | 5 | 2 | | | |
|--|--|--|--|--|--|--|---|---|---|--|---|--|-------------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Ulysses G Bigby</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>07 28 82</i> | | | | | 2b. HOUR <i>6:20 P.M.</i> | | | | | | | | | |
| 3. SEX <i>Male</i> | | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>12 28 1907</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University of Maryland</i> | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tailor</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. STATE <i>Md</i> | | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS <i>1615 Division St.</i> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i> | | | | | 16b. SOCIAL SECURITY NO. <i>212-03-9687</i> | | 17. INFORMANT <i>Otela Bigby (wife)</i> | | | | | ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>encephalopathy</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Renal Failure, Chronic Obstructive Lung Disease</i> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>82</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 6</i> 19 <i>82</i> to <i>July 28</i> 19 <i>82</i> that (I) (we) last saw the deceased alive on <i>July 28</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Fred Karlin</i> | | | | | DEGREE <i>M.D.</i> | | | | | 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Fred Karlin</i> | | | | | 22e. ADDRESS <i>22 E Greene Baltimore</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | 23b. DATE 7-31-82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | | | | 25b. REGISTRAR'S SIGNATURE <i>Sharon J. [Signature]</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|--|----------------------------------|--|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | 7 2 1 7 3 5 3 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| ETHEL AUGUSTA BING | | | | | 7-11-82 | | | | | |
| 3 SEX | | 4. RACE | | 5 DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| F | | W | | 10/22/04 | | 77 YRS. | | 7:30 M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Md. | | U. S. A. | | | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Balto. | | St. Agnes Hospital | | | | Housewife | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md. | | | | | Balto. | | Balto. | | 5908 Edmondson Ave. | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Charles Rau | | | | | Mary E. Browning | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| | | | | | 214-66-3727 | | J. Charles Bing 3204 Jean Ct., Chesapeake, Va. 23323 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| 1832 IMMEDIATE CAUSE (a) <u>Natutatal Carcinoma of Fallopian tubes</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| <u>Urinary Tract Infection</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> 19 <u>82</u> , to <u>July 10</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>July 10</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| <u>Charles Rau</u> | | MD | | | | | | 7-11-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 7-13-82 | | Oakland Mill Cem. | | Carroll Md. | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| G. Truman Schwab, P.A. | | 5151 Balto. Nat'l. Pike #21229 | | | | JUL 14 1982 | | | | |



Mr. J. A. ... Baltimore City

St. James Hospital ...

Mr. ... Baltimore ...

Charles ...
Mary ...
2504 Jean St.,
Va. 22322



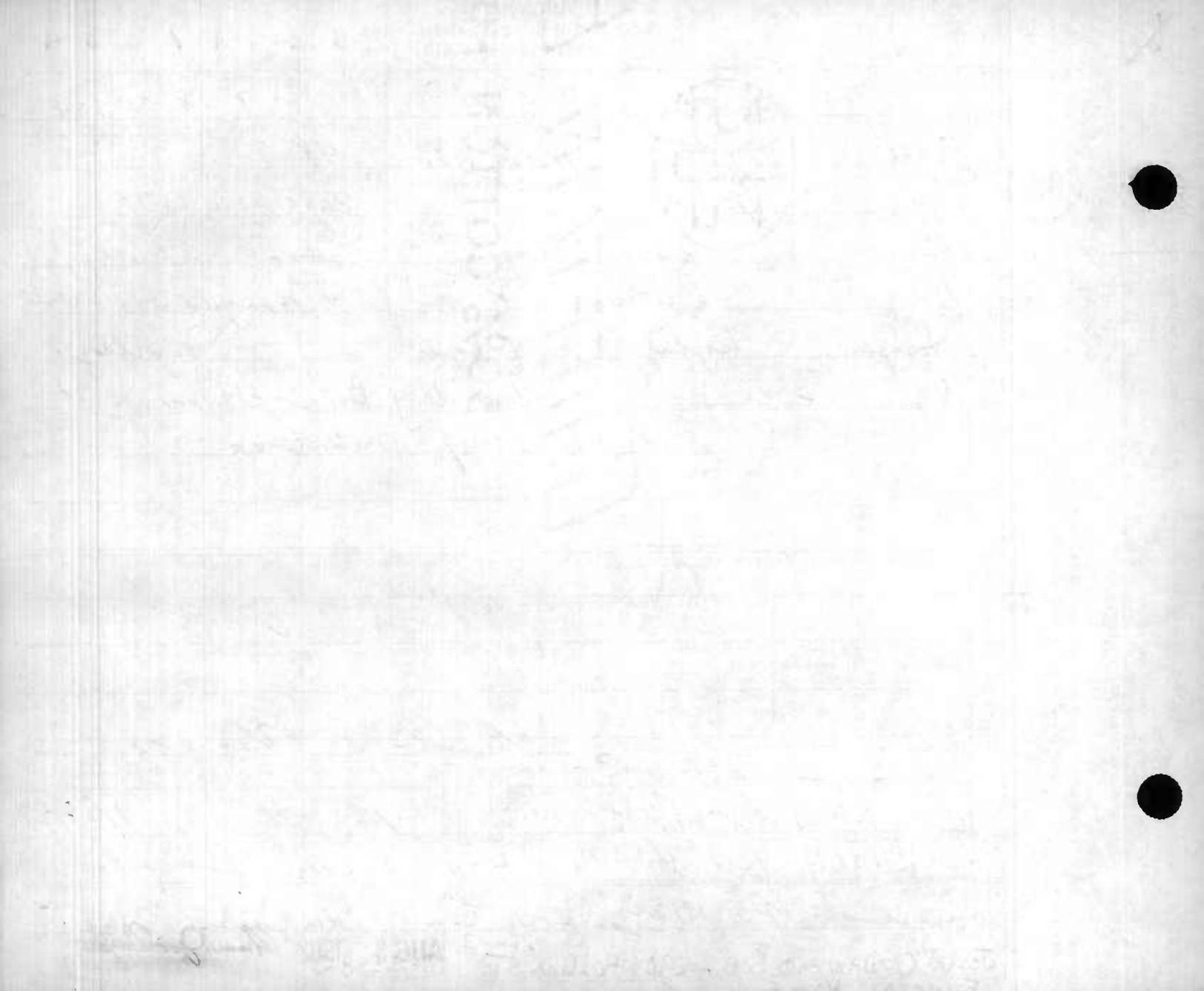
7-12-82 ...
2121 ...
P.O. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 8 2 1 7 3 5 4 | | | | | | |
|--|--|--|--|--|----------------------------------|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | | | | 07 28 82 | | | | | 1:50P M | |
| 1. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | |
| Male | | White | | 11-12-1933 | | 48 | | YES | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7c. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Ind. | | U.S.A. | | | | Baltimore city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Bon Secours Hospital | | | | Labour | | Trucking Co. | | | |
| 13a. USUAL RESIDENCE (IF MARLING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS | | | | | |
| Ind. | | Baltimore | | YES | | 814 Mergel St. 21230. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| Joseph Bishop | | Olga Worley | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| No | | | | Anne May Bishop - 814 Mergel St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CA of lung metastasis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN (a) AND DEATH | |
| 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | 6/1 82 07/28 82 | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Kuang-yen Huang | | | | M.D. | | | | 7/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| KUANG-YEN HUANG | | | | Bon Secours Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 7-31-1982 | | Green Haven Cem | | Baltimore Ind. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR | | 26. SIGNATURE | | | | | |
| JOHN COWAN AND SON INC. 901 Hollins ST. 21223 | | | | AUG 28 1982 | | | | | | | |
| FURNERAL HOME | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

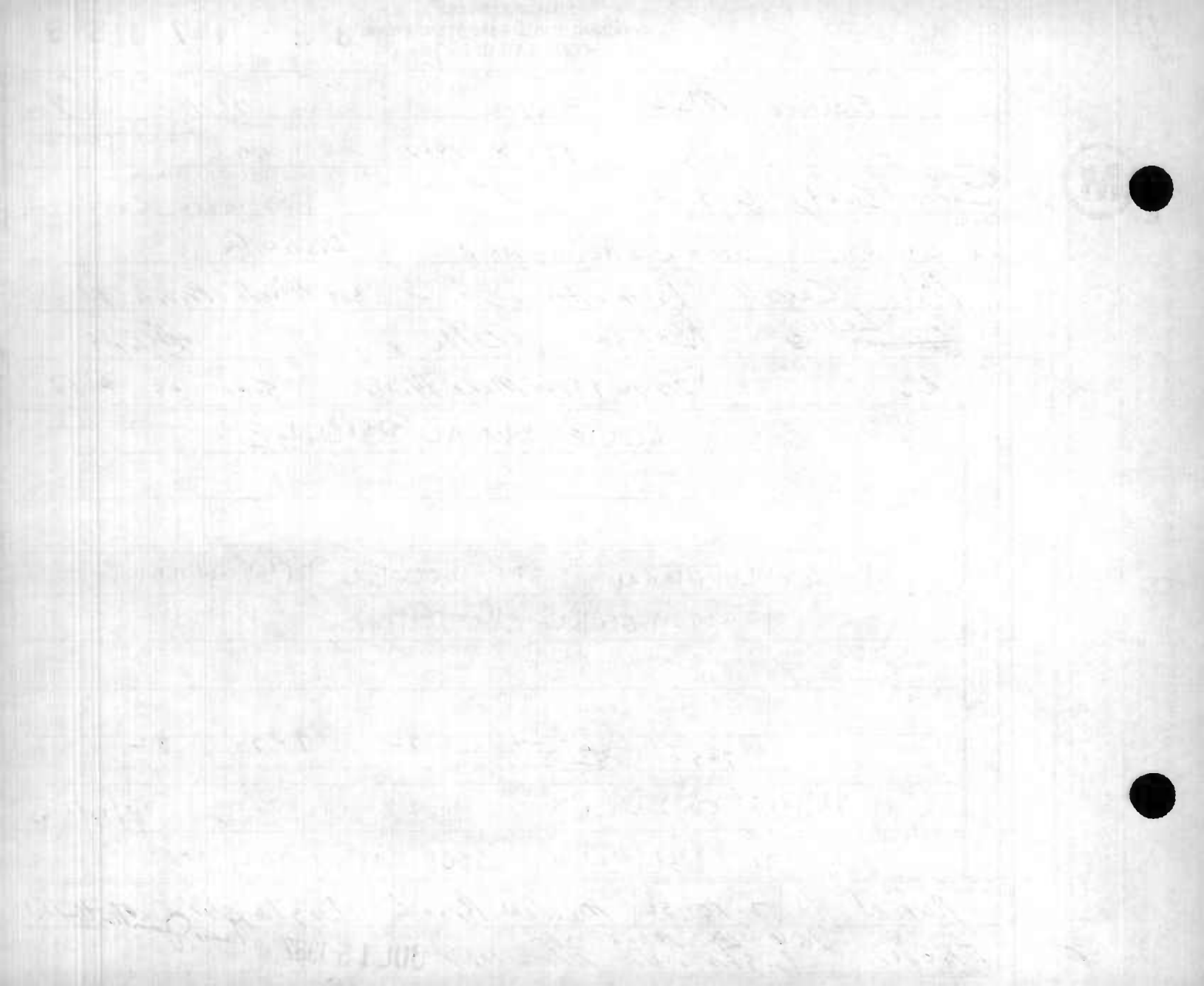
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE Mae BIXLER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/9/82 | | 2b. HOUR 10:37 AM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 12-8-1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll County | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY Carroll | 13c. CITY OR TOWN Westminster | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Levi Nusbaum | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Byers | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-14-9743 | | 17. INFORMANT ADDRESS Mary Nier SAME AS 4/13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5860 ACUTE PRIMAL FAILURE | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SLIP EXPLORATORY SM. BOWEL OBSTRUCTION | | | | | |
| 19a. DATE OF OPERATION 7-9-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SM. BOWEL OBSTRUCTION | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-24-82 , 19 82 , to 7-9-82 , 19 82 , that (I) (we) last saw the deceased alive on 7-9-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Albert du Cro | | DEGREE | | 22c. DATE SIGNED 7/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) AUGUSTO DEL CORRAL | | 22e. ADDRESS GOOD SAMARITAN HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadow Branch | |
| 23d. LOCATION Westminster | | 23e. COUNTY Carroll | | | |
| 24. FUNERAL DIRECTOR NAME Fletcher | | 24b. ADDRESS 254 E. Main St. Md. 21157 | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 3 5 6
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ALLEN N. BLADES

2a. DATE OF DEATH MONTH DAY YEAR
JULY 18, 1982

2b. HOUR
2:49 pm

3. SEX
Male

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
Aug. 28, 1893

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
88

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md.

7b. CITIZEN OF WHAT COUNTRY?
U. S. A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Church Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Carnival Games Owner

12b. KIND OF BUSINESS OR INDUSTRY
Owner-Carnival

13a. STATE
Md.

13b. COUNTY

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
34 N. East Avenue

14. FATHER'S NAME FIRST MIDDLE LAST
John D. Blades

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Bertha R. Wallace

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
218-14-1350

17. INFORMANT Catonsville, Md. 21228 -Place
Mrs. Ethel L. Hastings-409 Wheaton

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL LOWER LOBE; PNEUMONIA
0389
DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE SEPTICEMIA
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
DEHYDRATION

19a. DATE OF OPERATION
JULY 18 1982

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from JULY 18 1982, to JULY 18 1982, that (I) we lost the deceased alive on JULY 18 1982, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.

22b. SIGNATURE
A. F. NOUR

DEGREE
MD

22c. DATE SIGNED
7-18-82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. F. NOUR

22e. ADDRESS CHURCH HOME CORP.
100 N. BROADWAY BALTIMORE, MARYLAND, 21231

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
7/21/82

23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland

24. FUNERAL DIRECTOR NAME
Starling Funeral Estate

25a. DATE REC'D. BY REGISTRAR
JUL 19 1982

25b. REGISTRAR'S SIGNATURE
Charles J. Van Thier

RECEIVED

NOV 14 1963

NOV 14 1963

NOV 14 1963

NOV 14 1963

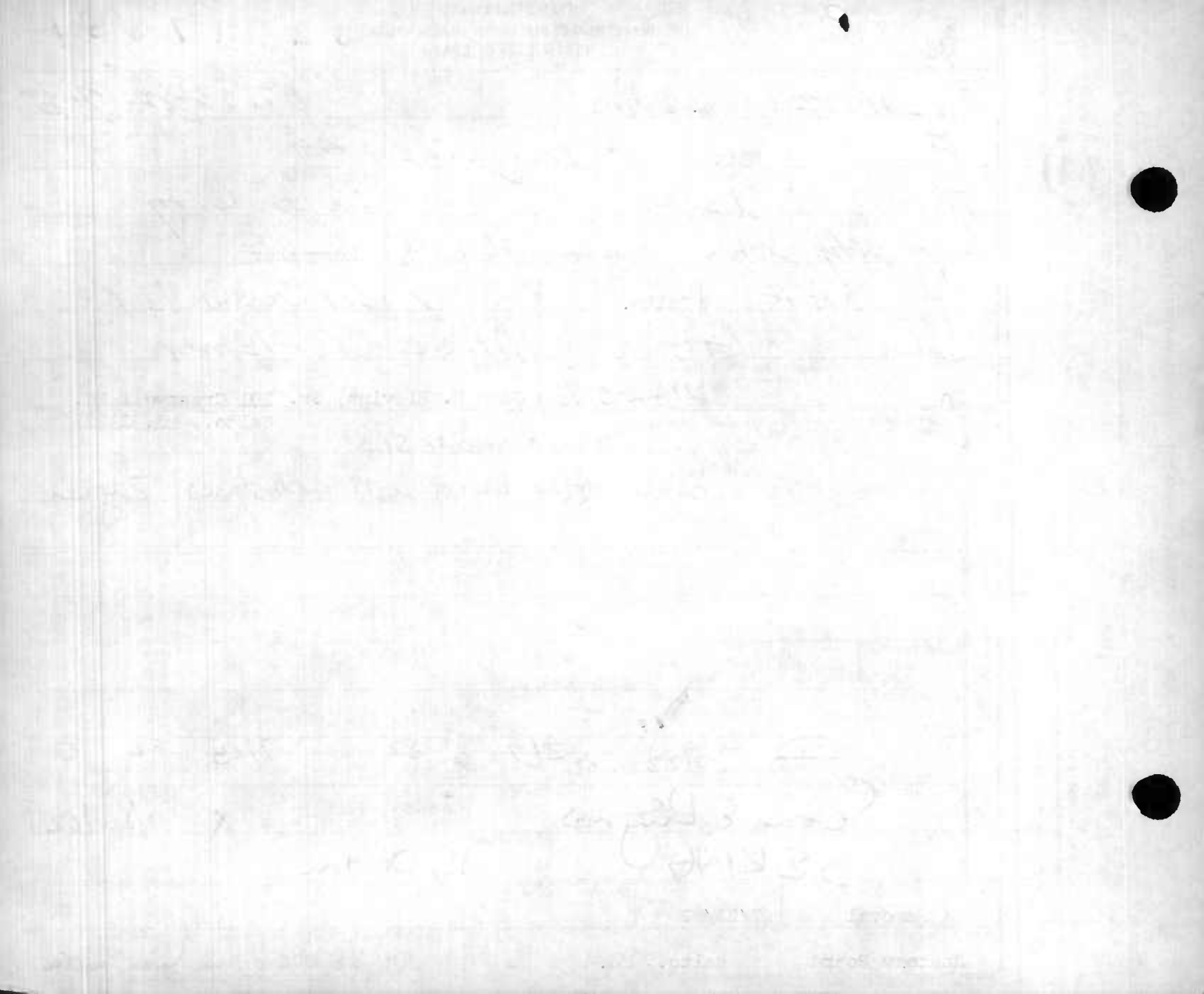
NOV 14 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 3 5 7 | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth L. Blevins | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-23-82 | | | | 2b. HOUR 7:22 AM | | | |
| 3. SEX F | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10-03-32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) In. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton Med. Ctr. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. P.A.A. | | | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 201 Cresswell Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Griffin | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Castelman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-26-5672 | | 17. INFORMANT ADDRESS John W. Blevins, Sr. 201 Cresswell Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) cancer of the breast with metastases Zys DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMINATION 21-225 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 2/23 19 82 to 7/23 19 82, that (I) we last saw the deceased alive on 7/23 19 82, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE D E KING | | | | DEGREE DEATON | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D E KING | | | | 22e. ADDRESS 201 Cresswell Rd. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | | 23b. DATE 7/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 5 8

REG. NO.

1. FOR
STATE
REGISTRAR

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|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) S E L M A | | FIRST MIDDLE LAST B L O C K | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1982 | | 2b. HOUR 7:35P M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 27, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 6600 EBERLE DR., APT. 202 #21215 | | 14. FATHER'S NAME FIRST MIDDLE LAST JACOB LEVIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE HOFFMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220-03-5564A | | 17. INFORMANT MR. AARON BLOCK | | 6600 EBERLE DR. APT. 202 BALTO., MD 21215 | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS. 20 YRS. |
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

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| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7-20 , 19 82 , to 7-27 , 19 82 , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on 7-27 , 19 82 , and that in <input checked="" type="checkbox"/> my (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> We could not notify the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. A. REISCHEN | | 22e. ADDRESS LEVINDALE | | | | | |

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|---|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 29, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN | | 23d. LOCATION CITY BALTIMORE COUNTY MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) AUG - 3 1982 [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>Item 13c per phone 7/29/82 dad</p> <p>FOR 1- STATE REGISTRAR</p> </div> <div> <p>REG. NO.</p> </div> </div> | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LIZZIE BLUNT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-20-82 | | | 2b. HOUR 8:40 P.M. | | |
| 3. SEX F. | | 4. RACE B. | | 5. DATE OF BIRTH MONTH DAY YEAR 6-18-10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Calhoun, S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DIETITIAN | | 12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL | | |
| 13a. STATE Md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN CHARLEY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NEILLIE JONES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 216-20-9786 | | 17. INFORMANT ADDRESS SAMUEL GLOVER 17 BERNICE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident - Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CAD | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/17 19 82 to 7/20 19 82 that (I) (we) lost saw the deceased alive on 7/20 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. SIGNATURE R. Williams | | | | | DEGREE MD | | | 23c. DATE SIGNED 7/21/82 | | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J Williams | | | | | 23d. ADDRESS 4200 EDMONDSON AVE 29 | | | | | |
| 23e. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23f. DATE 7-26-82 | | 23g. NAME OF CEMETERY OR CREMATORY ARBUTUS | | 23h. LOCATION CITY OR TOWN COUNTY STATE BALTO Md. | | | |
| 24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS | | | | | ADDRESS 1701 LAURENS | | 25a. DATE RECD. BY REGISTRAR JUL 23 1982 | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Frances Jan Thorne | | | | | |

51405

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 6 0

REG. NO.

1. FOR
STATE
REGISTRAR

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|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN U. BOBER | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 4, 1982 | | 2b. HOUR 10:55^P |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR May 16 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Steel |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Bober | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. 213-07-1840 | | 17. INFORMANT ADDRESS Julia Heyliger 5205 Kramme Ave. (21225) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE WITH SEVER HYPERKALEMIA AND METABOLIC ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE TUBULAR NECKOSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 25 , 19 82 , to JULY 4 , 19 82 , that (I) (we) lost saw the deceased alive on JULY 4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A.F. NOUR | | DEGREE M.D. | | 22c. DATE SIGNED 7/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.F. NOUR M.D. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MARYLAND 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/8/82 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 6 1982 | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy. | | 25c. REGISTRAR'S SIGNATURE James Van Kesteren | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed with the registrar's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 6 1 | |
|--|------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILDRED Naomi BOENNING | | | 2a. DATE OF DEATH MONTH DAY YEAR July 9 1982 | | 2b. HOUR 4:40 PM |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH MONTH DAY YEAR 11 11 09 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73 (72) | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Public Manor Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Curry | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 215-09-2180 | | 17. INFORMANT ADDRESS Betty M. Pagoota 861 Doris Dr. Arnold 21012 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) (POSS.) ASPIRATION PNEUMONITIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SEVERE CEREBRAL ARTERIOSCLEROSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 3 1982 to July 9 1982 , that (I) last saw the deceased alive on July 3 1982 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Ian Sunshine M.D. | | DEGREE | | 22c. DATE SIGNED 7/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IAN SUNSHINE | | 22e. ADDRESS 6210 PARK HTS AVE, BALT, MD 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc. | | ADDRESS 901 S. Conkling Street | | 25a. DATE REC'D. BY REGISTRAR 1111 12 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James Santhorne | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrator, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 3 6 2 | |
|---|--|---|--|--|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary M. Bogart | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 12, 1982 | | | 2b. HOUR M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 28, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 E. 30th St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Seamstress | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 524 E. 30th St. | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Eichler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-1708 | | 17. INFORMANT ADDRESS David B Jones Same | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) Carcinoma of the pancreas DUE TO, OR AS A CONSEQUENCE OF (b) with malignant coeliac DUE TO, OR AS A CONSEQUENCE OF (c) + obstructive jaundice As evi | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 9/9/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Pratima Bose | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pratima Bose, M.D. | | | | 22e. ADDRESS Mercy Hospital Baltimore, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be advised of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH | | 3. BALTIMORE CITY OR COUNTY OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE OF DEATH MONTH DAY YEAR | | 3. BALTIMORE CITY OR COUNTY OF DEATH | |
| AUDREY H. BOHAGER | | 7 20 82 | | BALTIMORE CITY MD. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. BALTIMORE CITY OR COUNTY OF DEATH | |
| Female | Cauc. | 6 23 1920 | 62 YRS | BALTIMORE CITY MD. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U. S. A. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | BALTIMORE CITY MD. | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | Housewife | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 16. INSIDE CITY LIMITS? | | 17. STREET ADDRESS | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. STREET ADDRESS | | |
| Maryland | Balto. | Lutherville | 204 E. Seminary Avenue | | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | |
| Hutchinson | Kroger | | 204 E. Seminary Ave | | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) | 18. SOCIAL SECURITY NO. | | 19. INFORMANT | | |
| No | 212-12-2339 | | Bernard Carl Bohager Sr. Lutherville Md. | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Brain tumor | | | | 4 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/17, 19 82, to 7/20, 19 82, that (I) (we) last saw the deceased alive on 7/20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Anthony D. ARZ MD | | MD | | 7/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | |
| Anthony D. ARZ MD | | Union Memorial Hospital Balt MD | | JUL 28 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 23 Jul 82 | | New Cathedral Cem. | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| Lemmon-Mitchell-Wiedefeld | | JUL 28 1982 | | Name of Registrar | |
| 24c. ADDRESS | | 24d. CITY OR TOWN | | 24e. STATE | |
| 10 W. Padonia Rd | | Baltimore | | Maryland | |

MEDICAL CERTIFICATION

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(R)

10-10-50

UNITED STATES DEPARTMENT OF THE ARMY
WASHINGTON, D. C. 20315

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE ARMY
SUBJECT: [illegible]

10-10-50

(R)

10-10-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 3 6 4 REG. NO. | | | |
|---|--|---|--|---|---|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR Mary T. Bolek | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARY T Bolek | | | | | 2a. DATE OF DEATH MONTH 07 DAY 01 YEAR 82 | | | | | 2b. HOUR 10:40AM | | | |
| 3. SEX Female | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH 08 DAY 26 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY | | 12b. KIND OF BUSINESS OR INDUSTRY EASTERN BOX CO. | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3709 7th Street | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE LAST Linsameyer | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Himmel | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-01-4786 | | 17. INFORMANT ADDRESS (WILLIAM J. BOLEK (SAME AS 13E)) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 2898 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) myelosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6/24/82 , 19 82 , to July 1 , 19 82 , that (1) (we) most saw the deceased alive on July 1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Alan N. Dennis | | | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/1/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan N. Dennis | | | | | 22e. ADDRESS 3001 S. Hanover St. Balto, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY | | STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME Balto., Md. 21225 George J. Gonce F.H. 4001 Ritchie Hgwy. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 2 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | | | | |

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22

George J. Jones, P. M. Wood, Albany, N. Y.

Albany, N. Y.

July 10, 1890

Albany, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

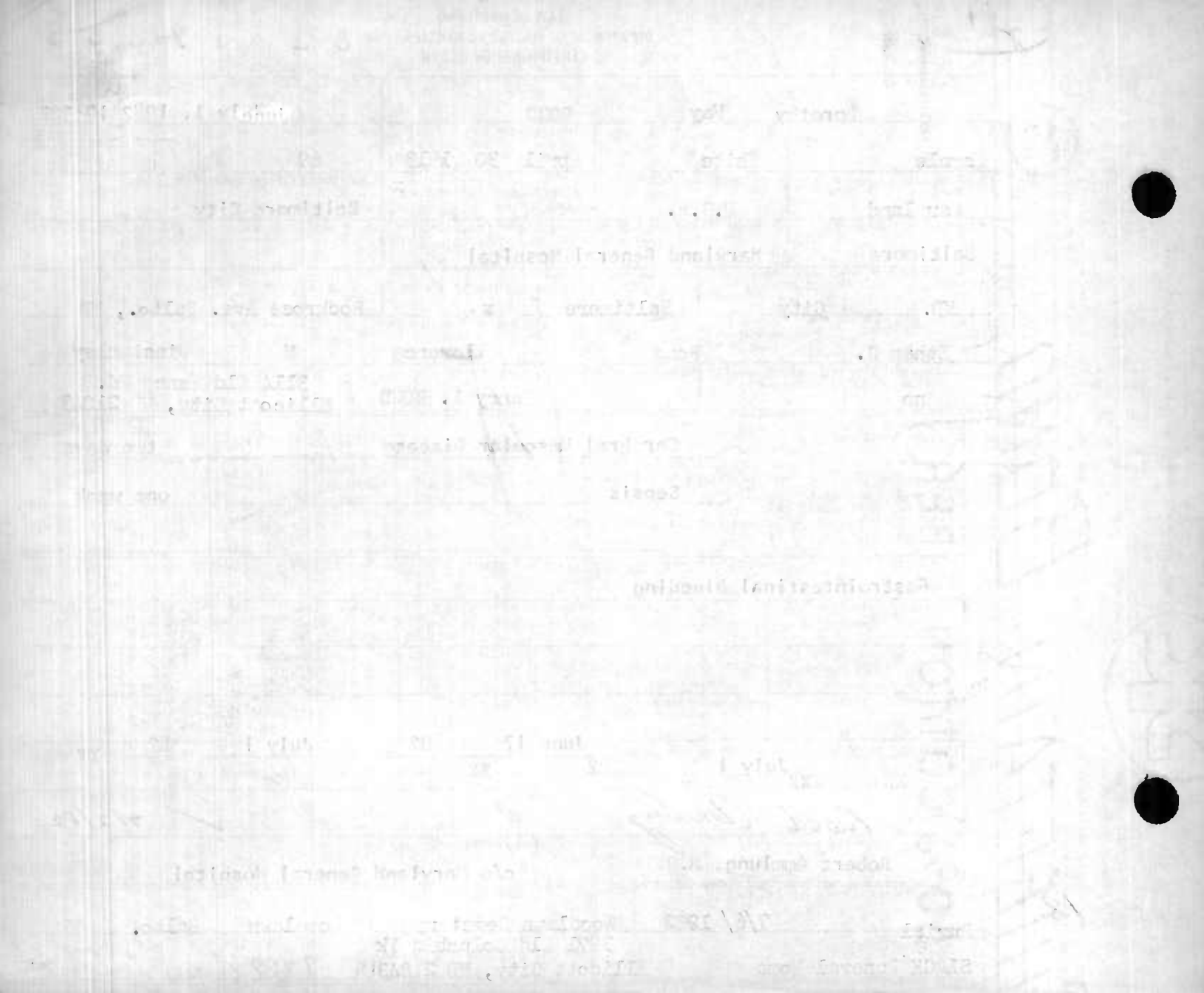
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 6 5

REG. NO.

| | | | | | | | |
|--|--|--|---|--|-----------------------------------|--|----------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | Dorothy May BOND | | July 1, 1982 | | 10:30P M | |
| 1. SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | White | April 30 1913 | 69 YRS. | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Maryland General Hospital | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MD. | | City | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Rockrose Ave. Balto., MD | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Ethan G. Bond | | Florence Winstanley | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| no | | | | Harry R. BOND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | two days | | | |
| 43779 | | DUE TO, OR AS A CONSEQUENCE OF | | one week | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Sepsis | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Gastrointestinal Bleeding | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from June 17 19 82 to July 1 19 82, the XX (we) last saw the deceased alive on July 1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Robert Ammlung | | MD | | | | 7/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Robert Ammlung, M.D. | | c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/6/1982 | | Woodlawn Cemetery | | Woodlawn Balto. MD | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| SLACK Funeral Home | | 3871 Old Columbia Rd Ellicott City, MD 21043 | | JUL 7 1982 James Van Kester | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 6 6 | | | |
|--|--|--|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST HETTIE H BONNELL | | | | MONTH DAY YEAR HOUR JULY 6 1982 3 P.M. | | | |
| 3 SEX F | | 4. RACE CAU | | 5. DATE OF BIRTH MONTH DAY YEAR FEB 4 1970 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3900 N. Charles St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Hazlett | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie List | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 24-01-5427 | | 17. INFORMANT ADDRESS ROBERT BONNELL JR 5 STRATFORD RD BALTO 21208 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS 1952 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CORONARY ATHEROSCLEROSIS WITH CHRONIC BRANCH SYNDROME | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Aug 1976, to 7/6 1982, that (I) (we) last saw the deceased alive on 7/3 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles O'Donovan III, MD | | | | DEGREE MD | | 22c. DATE SIGNED 6 July 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES O'DONOVAN III, MD | | | | 22e. ADDRESS 9 E. CHASE ST BALTIMORE, MD 21202 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 7/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

SECTION 11

WINDY



for 1st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 3 6 7 | | | |
|---|--|---|--|--|--|---|--|--|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Catherine Bon Seigneur | | | | 7 25 1982 | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 7. IF UNDER 24 HRS | |
| Female | | Cauc. | | 4 15 1900 | | 82 | | MONTHS DAYS | | HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | U.S.A. | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 2800 Jefferson St. | | | | Housewife | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2800 Jefferson St. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | |
| Conrad F. Bon Seigneur | | | | Lydia Gephhardt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| | | 217-12-3418 | | Paul Franz | | 407 Stevenson La. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLECTIC CARDIO-VASC. DISEASE</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE VASC. DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1975, to _____, 1982, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>ANDREW LEHUSCHNITZ</u> | | | | MD | | | | 7-27-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| ANDREW LEHUSCHNITZ MD | | | | 2608 E. Baltimore St - BALTO 21224 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 7/28/82 | | Loudon Park Cem. | | Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | | | |
| B. Dabrowski & Son 2818 E. Baltimore St. | | | | | | | | | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

On March 2, 1968

Re: Baltimore

Female, 4, 12 1970, 22

Mr. J. Edgar Hoover, Director, FBI, Washington, D.C.

Baltimore, 2000 Jefferson St., Housewife

Mr. J. Edgar Hoover, Director, FBI, Washington, D.C.

Re: Baltimore, 2000 Jefferson St., Housewife

217-12-3418 and 217-12-3419

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

The LHM is being furnished to the Bureau for your information and for the Bureau's files.

Very truly yours,

Special Agent in Charge

Enclosure

217-12-3418

217-12-3419

217-12-3420

217-12-3421

217-12-3422

217-12-3423

217-12-3424

217-12-3425



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 6 8

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS J. BOOKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 22 82 | | | 2b. HOUR 8:22 AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 09 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech. Equip. | | 12b. KIND OF BUSINESS OR INDUSTRY Utilities | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY A. A. | | 13c. CITY OR TOWN Glen Burnie | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George = Baylor | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie = Grund | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW=2 | | 17. INFORMANT Irma Booker | | ADDRESS same as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Nutritional Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>"</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Peritonitis 2° to migrated Mesocaval Shunt prosthesis THROMBOSED</u> | | | | | | | | |
| 19a. DATE OF OPERATION <u>July 9 1982</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Portal hypertension</u> | | 20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>7/4/82</u> , 19____, to <u>7/22/82</u> , 19____, that (we) lost saw the deceased alive on <u>7/22/82</u> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Robert E. Cranley</u> | | | | DEGREE <u>MD</u> | | 22c. DATE SIGNED <u>7/22/82</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT E. CRANLEY, M.D. | | | | 22e. ADDRESS St. Agnes Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 7/24/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore = Maryland | | |
| 24. FUNERAL DIRECTOR NAME Raymond C. Fink | | | | ADDRESS Glen Burnie, Md. | | 25a. DATE REC'D BY REGISTRAR JUL 26 1982 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1933

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[Faint text at the bottom of the page, likely bleed-through from the reverse side.]

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

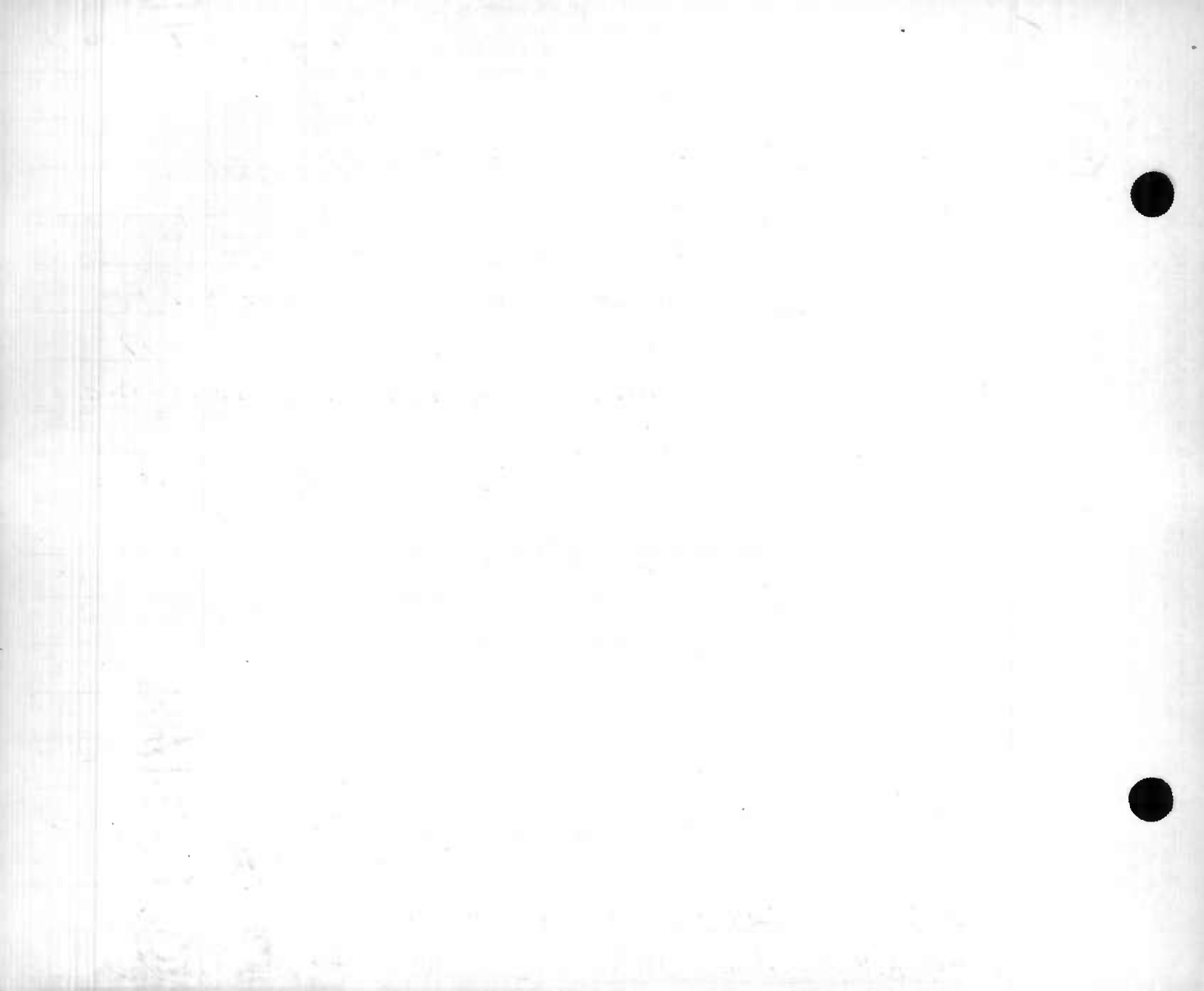
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 6 9
REG. NO.

| | | | | | | |
|---|--|--|---|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Virginia E Boone | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-15-82 | | 2b. HOUR M | |
| 3. SEX Fe | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 26 1908 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | 7. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Isle of Wgt VA. | | 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN BALTO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lee Uzeil | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Council | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-09-7013 | | 17. INFORMANT ADDRESS Keith Speed - 1508 Luzerne Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hyper Tensive Cardiovascular Dr. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr. 15 hr. 25 hr. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 19 56 to July 19 82, that (I) (we) lost saw the deceased alive on July 12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE William C. Wade | | | | 22c. DATE SIGNED 7-17-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Wade M.D. | | | | 22e. ADDRESS 3005 Duncow Rd - Balto Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. NAT. Mem PK. | | |
| 24. FUNERAL DIRECTOR NAME JAMES A. MORTON & SONS | | ADDRESS 1701 LAURENS | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Rogers | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 3 7 0 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie D. Boozer | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 15, 1982 | | 2b. HOUR 3:00a M | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 25 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 79 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 11 W. 20th St. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Neroy Dawkins | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 219-30-8450 | | 17 INFORMANT ADDRESS John W. Boozer 11 W. 20th St. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prolonged Coma 4939 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (c) Asthma, Acute Attack | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from June 26 19 82 , to July 15 19 82 , that (X) (we) lost saw the deceased alive on July 15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Bruce Paul Bollens MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce Paul Bollens, M.D. | | | | 22e. ADDRESS C/O Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Laurel MD | | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

July 17, 1952

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Baltimore City

Maryland General Hospital

Baltimore

10

100000

Professional fees

Cardiomyopathy arrest

Respiratory arrest



July 15

July 15

Maryland General Hospital

Dr. Paul Wolfson, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 7 2 1 7 3 7 1 | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARIE BERTHA BORMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 2 82 | | 2b. HOUR 10³⁵ PM | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 07 08 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GENERAL HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MD | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Columbia | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES Kiernan | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE BERTHA | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 055-10-2184 | | 17. INFORMANT ADDRESS Peter Borman 6426 Skyward Ct. Columbia 21045 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 1749 DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN TUMOR, METASTATIC DUE TO, OR AS A CONSEQUENCE OF (c) BREAST CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-26-82 to 7-2-82 , that (I) (we) last saw the deceased alive on 7-2-82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Peter H Cooke | | | | DEGREE MD | | 22c. DATE SIGNED 7-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter H Cooke | | | | 22e. ADDRESS 3001 S Hanover, Balto, 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery | | 23d. LOCATION CITY OR TOWN STATE Lynbrook New York | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Harry H Witzke 4112 Columbia Rd Ellicott City | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | | |

BP



NOTICE
FOR

July 8, 1982 Knoxville Community Improvement New York

July 7, 1982 Knoxville Community Improvement New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 7 2

REG. NO.

| | | | | | | |
|--|--|--|--|---|-----------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM STEWART BOTELER | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 3, 1982 | | 2b. HOUR 2:15aM | |
| 1. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL ADDRESS) CHURCH HOME HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BUS. DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION |
| 13a. STATE MD. | | | 13b. COUNTY BALTO CITY | | 13c. CITY OR TOWN BALTO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HARRY BOTELER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARSETHA A. STEWART | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 146 05 5161 | | 17. INFORMANT NAME ADDRESS HARRY DAVID BOTELER Box 319E BALDWINVILLE VA. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) HEART CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) EXACERBATION OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CANCER OF METASTASIS | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-14 19 82 , to 7-3 19 82 , that (I) (we) last saw the deceased alive on 7-3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Mukesh Luhar | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MUKESH LUHAR | | | | 22e. ADDRESS 100 N. BROADWAY CHURCH HOSPITAL BALTIMORE, MD. 21231 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF | | |
| 23d. LOCATION (CITY OR TOWN) ANNAPOLIS | | 23e. COUNTY ANNAPOLIS | | 23f. STATE MD | | |
| 24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPL. | | ADDRESS ANNAPOLIS, MD. | | 25. DATE REC'D. BY REGIS. (PART 751 REGIS. SIGNATURE) JUL 8 1982 | | |



White 1212 10
X
CHURCH
MD
HARRY
10



10
HARRY
CHURCH

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|---------------------|---|---|---|------------------------------------|--|---|--|---|-------------------|----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | SUE MI BOUCHER | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-2-82 | | | 2b. HOUR 19 | | | |
| 3. SEX Female | 4. RACE Oriental | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 10, 1954 | 6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 7c. DATE PRONOUNCED DEAD 7-2-82 | 7d. HOUR 19 | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | 2d. HOUR 9:30A | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital S.T.U. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Lansdowne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2946 Lake Brook Circle | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hyo Kun Lee | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST K Im Chong | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 087-56-8806 | | 17. INFORMANT Mark S. Boucher | |
| 16c. ADDRESS Same | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8188 IMMEDIATE CAUSE (a) Blunt injury to the head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY 5:50PM MONTH DAY YEAR 6-27-82 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject exited from moving vehicle | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgwY. | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 250ft. W. of intersection of Mapes Rd. & Hawkins Dr. Ft. Meade, Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 7-3-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE July 6, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212 | | | ADDRESS 6500 York R d | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | | 25b. REGISTRAR'S SIGNATURE Anne Queen | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) - FIRST MIDDLE LAST EVELYN MARGARET BOVA | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-24-82 | | 2b. HOUR 12:50 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 08 03 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Op. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Perce Anders | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carberry | | 13c. STREET ADDRESS 331 Arion Park Road 21229 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 213-20-2836 | | 17. INFORMANT ADDRESS Richard A. Bova 1546 Ingleside Ave. 21207 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1551 IMMEDIATE CAUSE (a) Intestine, Metastatic CA DUE TO, OR AS A CONSEQUENCE OF Biliary obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Poorly differentiated Cholangio carcinoma DUE TO, OR AS A CONSEQUENCE OF > 7 weeks PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION 6/15/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Biliary obstruction | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1982 to 24 June 1982 , that (I) (we) last saw the deceased alive on 23 July 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Ted Wesley Switzer MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 24 July 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) TED WESLEY SWITZER MD | | 22e. ADDRESS 900 S. Calver Ave, Baltimore MD 21279 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. | | 23d. LOCATION CITY OR TOWN Baltimore | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | |

RECEIVED



[Faint, mostly illegible handwritten text covering the majority of the page. Some words like "received" and "sent" are visible.]

204-154

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|-------------------------|--|--|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES Thomas BOWEN | | | 2a. DATE OF DEATH KNOWN ESTI- MATED <input checked="" type="checkbox"/> 7-3-82 19 | | | 2b. HOUR M AM | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 6 29 21 | 6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7-3-82 19 | 2d. HOUR 8:10P | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 2130 Lodge Forest Drive | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Bowen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Kelly | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT 2130 Lodge Forest Drive Margaret H. Bowen Balto., MD. 21219 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): carcinoma of lung | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-4-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/7/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |



1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Greely W. Bower | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 26 82 | | | 2b. HOUR 3 P. | | | |
| 3 SEX Male | | 4. RACE Cauc | | 5. DATE OF BIRTH MONTH DAY YEAR 12 17 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1607 Malvern Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William W. Bower | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie L. Riggs | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 232-05-7094 | | 17. INFORMANT Emily F. Bower | | ADDRESS 1607 Malvern St. Balto., MD. 21224 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, severe DUE TO, OR AS A CONSEQUENCE OF: (b) Severe arteriosclerotic heart disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (c) Cardiomyopathy | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-12-82 to 7-26-82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 7-26-82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M. Nestor | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 7-26-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Nestor | | | | | 22e. ADDRESS 3001 S. Hanover St | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/31/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nestor | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 3 7 7 | | | |
|---|--|---|--|---|--|---|--|
| 1- STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | REG. NO. | | | |
| FIRST MIDDLE LAST Nellie M. BOWERS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR July 1, 1982 10 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 16 1908 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Carney | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Percy T. Stansbury | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Heimiller | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO. 217-36-3452 | | 17. INFORMANT ADDRESS Ronald G. Bowers, 20 Alston Rd., Lutherville | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5325 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Probable Perforated Duodenal Ulcer DUE TO, OR AS A CONSEQUENCE OF (c) 24 hours. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Small cell lung cancer | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the physician) attended the deceased from June 22, 1982, to July 1, 1982, that (I) (we) last saw the deceased alive on July 1, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Paul Chang, M.D. | | | | DEGREE | | 22c. DATE SIGNED 7/1/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Chang, M.D. | | | | 22e. ADDRESS Good Samaritan Hospital, Baltimore. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-3-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Maryland | |
| 24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Nuthan | |

14

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

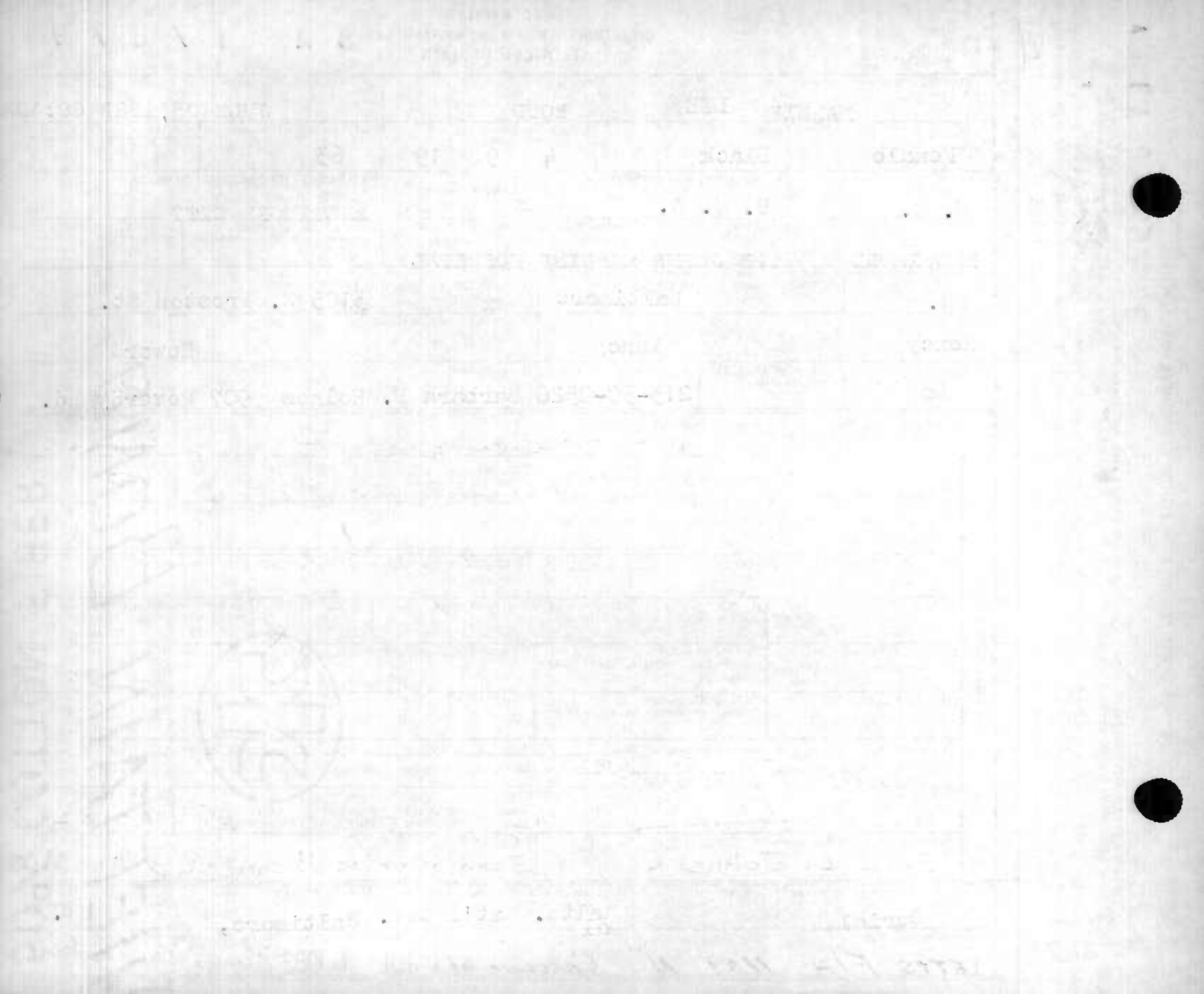
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|---|-----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 7 2 1 7 3 7 8 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN Bowler | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 23 82 | | 2b. HOUR 7:45 A M | | |
| 3. SEX MALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 29 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dukeland Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deliveryman | | 12b. KIND OF BUSINESS OR INDUSTRY Drugstore | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2127 Bolton Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Bowler | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Ann Holmes | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown | | 16b. SOCIAL SECURITY NO. 147-07-9556 | | 17. INFORMANT ADDRESS Bladys Singleton 3102 Brightwood Ave. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of Colon & metastasis 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 06/25 82 7/23 82 | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/22 82 to 7/23 82 , that (I) (we) lost saw the deceased alive on 7/22 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Kuang-Yen Huang M.D. | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG | | | | 22e. ADDRESS DUKELAND NURSING HOME | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8-2-82 | | 23c. NAME OF CEMETERY OR CREMATORY KING MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | | | ADDRESS 1721 N. MONROE ST. | | 25a. DATE REC'D BY REGISTRAR JUL 28 1982 | | REGISTRAR'S SIGNATURE James J. [Signature] | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) NANNIE LEE BOYD | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 05, 1982 | | 2b. HOUR 08:10A | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 9 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3105 E. Preston St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Rexcy Yancy | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Howard | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 213-30-8526 | | 17. INFORMANT ADDRESS Barbara E. Holmes 907 Reverdy Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>metastatic lung cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>primary adenocarcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>July 5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Eric L. Johnson</u> | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric L. Johnson | | | | 22e. ADDRESS Johns Hopkins Hospital, Balto., MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS BETTS F/H 1129 N. CAROLINE ST. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Frances Jan Nathan</u> | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17380 | | | |
|--|--|------------------|--|---|--|---|--|--|--|---|--|---|--|--|--|--|--|--|--|------------------|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Regina Elizabeth Boyd | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 15 19 82 | | | | | | | | | | 2b. HOUR M 7:05A | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 14, 1949 | | 6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 7 16 19 82 | | | | | | | | | | 2d. HOUR 7:05A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hagerstown, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Side/University Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 50 Summit Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Blaine Boyd | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Elizabeth "Deatrich" | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none | | | | 17. INFORMANT ADDRESS Esther E. Boyd, Maugansville, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9571 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR XX P.M. MONTH 7/15 YEAR 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Jumped from the 11th floor fell to ground | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22 S. Greene Street, Baltimore, MD | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H. R. Guard</i> | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 7/16/82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE July 18, 82 | | 23c. NAME OF CEMETERY OR CREMATORY Smithburg Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Smithburg, Washington, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc. | | | | 1601 Penna. Ave, Hagerstown, Md. | | | | 25a. DATE REC'D BY REGISTRAR JUL 21 1982 | | | | 25b. SIGNATURE <i>[Signature]</i> | | | | | | | | | | | |

MEDICAL CERTIFICATION

NO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 8 1

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET EMMA BOYER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 3 82 | | 2b. HOUR 4⁰⁵ A M |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 5 12 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS + |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY — |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY — | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK W. BRAUN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE FRANKLIN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-10-5447 | | 17. INFORMANT ADDRESS JAMES L. BOYER 6012 CLAIRE ROAD 21227 ELKRIDGE, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: — | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19 — | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) — | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | |
| 22a. I certify that (I) (his hospital) attended the deceased from 1 JULY 1982 to 3 JULY 1982 , that (I/we) lost saw the deceased alive on 3 JULY 1982 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death. | | | | | |
| 22b. SIGNATURE Andrew F. Trope | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW F. TROPE | | 22e. ADDRESS 900 CATON AVE. BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-07-82 | | 23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PK. | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | ADDRESS 4107 WILKENS AVE. | | 23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND | |
| 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 8 2

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM W. Boyer | | | 2a. DATE OF DEATH MONTH DAY YEAR July 24-82 | | | 2b. HOUR 40 6 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 22 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator-P.B.G. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4414 Frederick Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Westley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anderson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 8-18 to 1-19 | | 17. INFORMANT 4414 Frederick Ave., Mrs. Ethel S. Boyer #21229 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-14-1982 to 7-24-1982, that (I) (we) lost saw the deceased alive on 7-24-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. Devadoss | | | | DEGREE MD | | | | 22c. DATE SIGNED 7-24-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss | | | | 22e. ADDRESS Provident Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Md. | | | |
| 24. FUNERAL DIRECTOR NAME G. Truman Schwab, P.A. | | | | 3512 Frederick Ave., #21229 | | 25a. DATE REGD. BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 3 8 3

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MARIE BOYLES.

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
07/13/1982 9.30 A M

3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR
9 10 07 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE Gty MD.

10. CITY OR TOWN OF DEATH BALTIMORE 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Md. 13b. COUNTY BALTO. 13c. CITY OR TOWN TURNERS 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 8008 NORRIS

14. FATHER'S NAME FIRST MIDDLE LAST WILL Gladney 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN Dennis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS MR. WALTER BOYLES 8008 NORRIS LANE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT
DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DISEASE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/11/82, 19 82, to 7/13/82, 19 82, that (I) (we) last saw the deceased alive on 7/13/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 22c. DATE SIGNED 7/13/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANSARI A M.D. 22e. ADDRESS NORTH CHARLES GEN. HOSP. BALTIMORE MD 21218

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
Burial 7-17-82 Arboretus Baito Md

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
JAS. A. MORTON & SONS 1701 LAURENS ST. JUL 15 1982 Charles J. [Signature]



Q AND A

WIKI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ANNA BARBARA BRADLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1982 2:15 P | | | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 08 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter Shiples | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Kakpas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No. | | 16b. SOCIAL SECURITY NO. 219-48-1994 | | 17. INFORMANT ADDRESS Daniel F. Bradley same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>COPD</u> <u>INFECTED PACEMAKER LEADS</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/13/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INFECTED PACEMAKER LEADS | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:15 P.M. 7/23 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/82</u> 19_____, to <u>7/23</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Carlos Govantes | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/23/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLOS GOVANTES | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | |

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11

AXXA TASHANA HADEY JULY 23, 1968 2:12P

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BALTIMORE CITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 8 5 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Theodore R. Bracey | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/22/82 | | 2b. HOUR 5:30 A M | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 16 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Bracey | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie English | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 077-16-0203 | | 17. INFORMANT ADDRESS Annie Bell Bracey 633 Willow Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic pancreatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: d | | | | | | | |
| 19a. DATE OF OPERATION 6/14/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pancreatic resection | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from 6/14/82 to 7/22/82 , that (we) last saw the deceased alive on 7/22/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Nuslund | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nuslund | | 22e. ADDRESS Balt. City Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus mem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 25b. REGISTRAR'S SIGNATURE Frances Jan Nuthen | | | |

14

1944

1944-1945

1944-1945

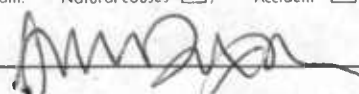

1944-1945

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1944-1945

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17386 | |
|--|---------------|--|--|--|------------------|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM B. BRADY SR. | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 28 1982 | | 2b. HOUR 9:31 a | | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 1-29-30 | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD 7 28 1982 | | 2d. HOUR 9:31 a | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. <u>Separated</u> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5810 Reisterstown Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stable Hand | | 12b. KIND OF BUSINESS OR INDUSTRY Race Track | | | |
| 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4200 Sheldon Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Patrick G. Brady | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Dean | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. Korean War 216-24-1857 | | 17. INFORMANT Lillian Ziska (sister) | | ADDRESS same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-28-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR Name Schimunek Funeral Home, Inc. Address 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | |

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| 200 | 7/31/51 | ... | ... |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 3 8 7 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Harry Brandchaft | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 - 10 - 82 | | 2b. HOUR 11 45 PM | |
| 3. SEX ♂ MALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 08 21 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | |
| 7a. BIRTHPLACE (COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FORM MOST OF WORKING LIFE) ATTY. | | 12b. KIND OF BUSINESS OR INDUSTRY SOC SEC. ADM. | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Isadore Brandchaft | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Wagner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 136-01-1053 | | 17. INFORMANT ADDRESS MRS. MARTHA BRANDCHAFT | | 17b. ADDRESS 2708 SULGRAVE AVE (21215) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) cardiopulmonary failure | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) pneumonia | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. chronic renal failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24/1982 to 7/10/1982 , that (I) (we) last saw the deceased alive on 7/10/1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE K. Robie Suh MD | | | | DEGREE MD | | 22c. DATE SIGNED 7/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. Robie Suh | | | | 22e. ADDRESS Univ. of Md. Hosp. Dept of Med Balto MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO, MD. | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO, MD (21215) | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE Frances J. ... | |

12

1. The first part of the report is a general
description of the project. It is a study of the
effect of the new law on the business community.
The second part is a detailed analysis of the
data collected. It shows that the law has had a
significant impact on the business community.
The third part is a conclusion. It states that the
law has been successful in achieving its purpose.
The fourth part is a list of references. It includes
the following sources: the new law, the data
collected, and the report of the business community.
The fifth part is a list of appendices. It includes
the following appendices: the data collected, the
report of the business community, and the new law.
The sixth part is a list of footnotes. It includes
the following footnotes: the data collected, the
report of the business community, and the new law.
The seventh part is a list of tables. It includes
the following tables: the data collected, the
report of the business community, and the new law.
The eighth part is a list of figures. It includes
the following figures: the data collected, the
report of the business community, and the new law.
The ninth part is a list of charts. It includes
the following charts: the data collected, the
report of the business community, and the new law.
The tenth part is a list of graphs. It includes
the following graphs: the data collected, the
report of the business community, and the new law.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR 1. STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 7 3 8 8 | |
|---|--|--|---|-------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | REG. NO. | |
| BRANT GUINEVERE E BRANT | | 7 15 82 | | 41 ⁰⁰ M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| FEMALE | CAU | 9 14 29 | 52 YRS | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| W. VIRGINIA | USA | | BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | UNIVERSITY OF MARYLAND | SOCIAL SECURITY | U.S. Gov. | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | ALLEGANY | CUMBERLAND | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | Massachusetts 230 MASSACHUSETTE AVE | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | |
| GEORGE | EAGLE | GLADYS SNYDER | | | |
| 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | |
| 236-42-0243 | WILLIAM REED / MEDICAL RECORD | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1539 IMMEDIATE CAUSE (a) Cardiac arrest | | | | | 24 |
| DUE TO, OR AS A CONSEQUENCE OF (b) Possible Myocardial Infarction | | | | | 24 |
| DUE TO, OR AS A CONSEQUENCE OF (c) Resection of Hepatic Metastases / Colon Cancer 64 | | | | | 64 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of colon | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 7/15/82 | Hepatic Metastases | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14/82, 19 82, to 7/15, 19 82, that (I) (we) last saw the deceased alive on 7/15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE OF PHYSICIAN | | DEGREE | | 22c. DATE SIGNED | |
| WILLIAM P. REED | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/15/82 | |
| 22d. ADDRESS | | 22e. ADDRESS | | | |
| | | 22 S. GREENE ST. BALTIMORE, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| Burial | 7-18-1982 | Sunset Memorial Park | Cumberland, Allegany, Md. | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE REC'D. BY REGISTRAR | |
| James F. Scarpelli | | JUL 19 1982 | | | |

James F. Campbell, Cambridge, Mass.

9-18-1985

Cambridge, Massachusetts

James F. Campbell

222 Essex St. Boston, Mass.

10/1/85

10/1/85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 3 8 9 | |
|--|-------------------------|---|---|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Reginald Holmes Breedon | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-29-82 | | 2b. HOUR 3:10 PM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 01/29/94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hosp. | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | | | |
| 13a. STATE MD | | 13b. COUNTY CATONSVILLE | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 5902 Robindale Rd. |
| 14. FATHER'S NAME FIRST MIDDLE LAST John W. Breedon | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret La Vaille | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW I | | 17. INFORMANT ADDRESS Catherine Breedon - Same as Sec. 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Malnutrition | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/28 , 19 82 , to 7/29 , 19 82 , that (I) (we) lost saw the deceased alive on 7/29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Bedri Yousif | | DEGREE MD | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEDRI YOUSIF | | 22e. ADDRESS St Agnes Hosp 900 CATON, Balt. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 31, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN Dorsey | | COUNTY Ho. | | STATE MD. | |
| 24. FUNERAL DIRECTOR'S NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | |
| 24b. ADDRESS 1630 Edmondson Ave. Catonsville, MD. 21228 | | | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | |

U.S.A.

1000 North Main St.

La Verne

Warrenton

Grassland

John

Cartwright - 1000 North Main St.

MI

Yes

Mrs. (Mrs.)

X

No. 100

July 21, 1982

2101

1000 North Main St. Cartwright, MI 49822

8 2 1 7 3 9 0

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>MORRIS</u> MIDDLE <u>BENJAMIN</u> LAST <u>BREYER</u> <u>BEN BREYER</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>JULY 6 1982</u> | | | 2b. HOUR <u>9:05 PM</u> | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>Caucasian</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>Dec. 25 1900</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>LATVIA</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE CITY</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>LEVINYAE HEDRON GERIATRIC CENTER - HOSPITAL</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>TAILOR</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u> | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u> 13b. COUNTY <u>BALTIMORE</u> 13c. CITY OR TOWN <u>BALTIMORE</u> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>LOUIS BREYER</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>SARAH UNKNOWN</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>215-07-5348</u> | | 17. INFORMANT <u>MRS. SARAH ALTHOFF</u> <u>2225 ROGENE DR., APT. 201 #21209</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SQUAMOUS CELL CARCINOMA, LUNG</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTH</u> | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>MAY 18</u> , 19 <u>82</u> , to <u>JULY 6</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>JULY 6</u> , 19 <u>82</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/6/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ESTRELLITA O. KIM, M.D.</u> | | 22e. ADDRESS <u>LEVINYAE HEDRON GERIATRIC CENTER - HOSPITAL</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>JULY 7, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SHAAREI ZION</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>ROSEDALE BALTO. MD</u> | |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTO. MD 21215</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 8 1982</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RECEIVED 10/10/1943

U.S. DEPARTMENT OF THE INTERIOR

OFFICE OF THE GEOLOGICAL SURVEY



RELEASED AS A NON-MED PER MR. HENRY & DR. DIXON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Thereafter, it is to be retained by the funeral director. Pages 2 and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 9 1

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY A. BRIDGEFORTH | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1982 | | 2b. HOUR 8:50A |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 11 14 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luellen Morgan | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Seward | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Ella M. Fowlkes 1516 E. Lanvale St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 28 , 19 82 , to 8:50 Am , 19 82 , that (I) (we) lost saw the deceased alive on July 28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE M. Sunday | | DEGREE MD | | 22c. DATE SIGNED 7/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. SUNDAY | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 8-1-82 | 23c. NAME OF CEMETERY OR CREMATORY Rosebudd Bapt. Ch. Dundas | | 23d. LOCATION CITY OR TOWN COUNTY STATE Va. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE James Jean Nathan | |

MEDICAL CERTIFICATION

P2 580

1- STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17392

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|--------------------------------------|--|--|--|----------------------------------|--|-------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| BERTHA | | | | | | BROADNAX | | 7 | | 27 | | 19 | | 82 | | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Female | | Black | | 1 18 23 59 | | YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 7 | | 27 | | 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | MD. | |
| Virginia | | U.S. | | | | | | | | | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Baltimore | | Maryland General Hospital (DOA) | | Daywork | | Private Home | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | | | |
| Md. | | | | Balto. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 2018 Madison Ave. | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | | | | | |
| Walter | | | | Madison | | Candis | | | | Williams | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | | | |
| Yes | | WWII | | 230-16-3602 | | Mrs. Clara Carter | | Balto., Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic cardiovascular disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 4292 | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | |
| ACTUAL SIGNATURE | | Ann M. Dixon | | TITLE (SPECIFY) | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED | | 7-28-82 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Ann M. Dixon, M.D. | | ADDRESS | | 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| Burial Removal | | 8/29/82 | | Crownsville Vet. Cem. | | Crownsville | | A.A. Co. | | Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | 24a. NAME | | 24b. ADDRESS | | 24c. DATE REC'D. BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Joseph L. Russ | | 2222 | | North Ave. Balto., Md. | | AUG 3 1982 | | | | | | | | | | | | | | | |
| Anatomy Board | | | | | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEMORANDUM

TO : [illegible]

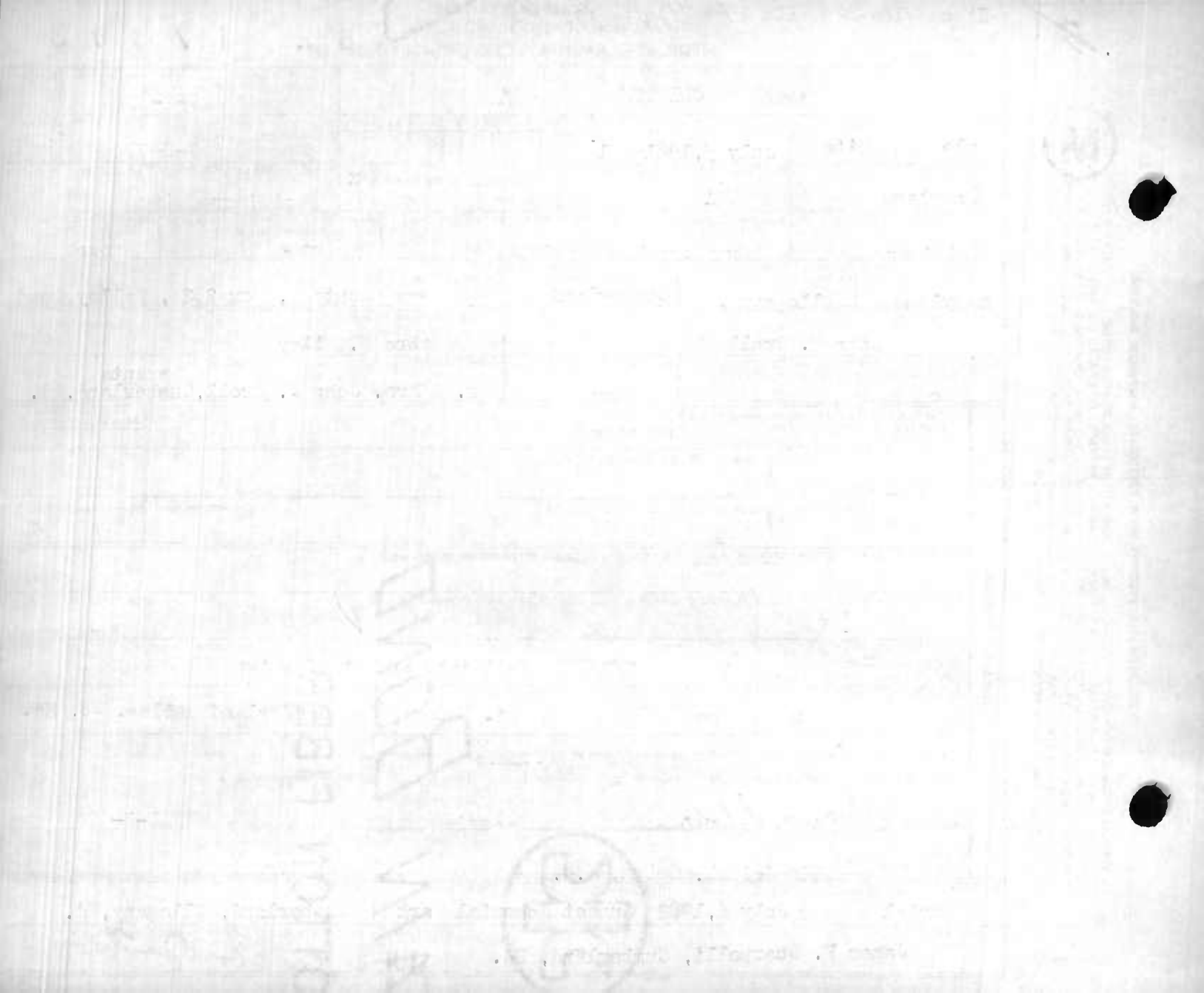
FROM : [illegible]

SUBJECT : [illegible]

LOW FLOOR

WIDE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 3 9 4 | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BYRON ELLSWORTH BROOKS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-1-1982 | | | | 2b. HOUR 9P. M. | | | |
| 3. SEX M | | 4. RACE C | | 5. DATE OF BIRTH MONTH DAY YEAR 09 12 26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shock Trauma / University of Md. | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursery Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Nursery | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Kingsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 12420 Jerusalem Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Byron H. Brooks | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie V. Layman | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.11 | | 17. INFORMANT ADDRESS Joyce S. Brooks Kingsville, Md. 12420 Jerusalem Road | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5770 Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ETOH abuse Acute Necrotizing enteropancreatitis. | | | | | | | | | | | |
| 19a. DATE OF OPERATION 6-29-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ac. Necrotizing Pancreatitis | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE K. Rathnakumar | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7-1-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. RATHNAKUMAR MD. | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7-3-82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pk. Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME E.F. LASSAHN FUNERAL HOME | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | | | 25b. REGISTRAR'S SIGNATURE | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the attending physician.

Item 4 per phone 7/26/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 7

3 9

5

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Catherine T Brooks. | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/13/82 | | | 2b. HOUR 3pm | | | |
| 3. SEX F | | 4. RACE Caucasian American | | 5. DATE OF BIRTH MONTH DAY YEAR 12 11 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK AND NATURE OF WORKING LIFE) Homemaker | | 15. KIND OF BUSINESS OR INDUSTRY | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5706 Greenspring Ave 21201 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David R. Ormond | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Sarah Roche | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 213368455 | | 17. INFORMANT Dr Kapoor | | | | ADDRESS Sinai Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 4275 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr Kapoor | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Kapoor | | | | 22e. ADDRESS Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/16/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore | | | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd. | | | | 25. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | | | |

also

resville

7/1, 1982

1981

its self-interest

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/BI
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 3 9 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CURTIS W. BROOKS | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 16 82 | | 2b. HOUR 3:10 AM |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 10 15 66 | | 6. AGE (IN YEARS LAST BIRTHDAY) 15 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN CITY | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES BROOKS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINDA HARGROVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 220-76-612 | | 17. INFORMANT ADDRESS Linda Hargrove 1927 McCulloh Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2001 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute lymphocytic leukemia 9 mos DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoblastic lymphoma 19 mos PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 15, 1982, to July 16, 1982, that (I) (we) last saw the deceased alive on July 16, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE David I. Otto MD | | DEGREE | | 22c. DATE SIGNED 7/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID I. OTTO | | 22e. ADDRESS University Hospital Dept of Pediatrics | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/20/82 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue | | 25a. DATE RECEIVED BY COUNTY REGISTRAR'S SIGNATURE JUL 20 1982 Frances Jan Nathan | | | |

MEDICAL CERTIFICATION



20% COTTON FIBER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, HEA
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17397 | |
|--|--|---------------|---|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | 7a. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN BROOKS | | | | | | | | | | 7b. HOUR M | |
| 3. SEX M | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Unknown | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YR. MONTHS DAYS | | 7c. DATE PRONOUNCED DEAD 7-20-82, 8:28A | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2027 Madison Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE md | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2027 Madison Ave | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Unknown | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. no | | 17. INFORMANT ADDRESS Mrs. Spread 2027 Madison Ave | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-20-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 23c. LOCATION CITY OR TOWN Balto Co | | COUNTY STATE md | | | |
| 24. FUNERAL DIRECTOR NAME Mary M. Wallace | | | | ADDRESS 3405 West Emden St | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | | | |

LIBRARY

BOOK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

item 6 #G570 8/9/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NATHANIEL T. Brooks | | | 2a. DATE OF DEATH MONTH 7 DAY 13 YEAR 82 | | | 2b. HOUR 1:55 PM | | | | | |
| 3. SEX MALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH 10 DAY 24 YEAR 1904 | | 6. AGE IN YEARS (LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS 78 DAYS 78 HOURS 78 MIN 78 | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 9. CITIZEN OF WHAT COUNTRY? U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTO City MD. | | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 18. STREET ADDRESS 1615 N. Smallwood Street | | | | | |
| 19. FATHER'S NAME FIRST unkn MIDDLE unkn LAST unkn | | | 20. MOTHER'S MAIDEN NAME FIRST unkn MIDDLE unkn LAST unkn | | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 22. SOCIAL SECURITY NO. 216-09-8095 | | | 23. INFORMANT ADDRESS Augusta C. Brooks 1615 N. Smallwood St. | | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) OSTEOSARCOMA METASTATIC to both lungs DUE TO, OR AS A CONSEQUENCE OF (c) Paget Dis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 25. DATE OF OPERATION 7/13/82 | | | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 34. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 35. I certify that (I) (this hospital) attended the deceased from 6/29 19 82 to 7/13 19 82 , that (I) (we) lost saw the deceased alive on 7/13 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 36. SIGNATURE E. EDWARD FRANKO | | | | | | 37. DEGREE MD | | 38. DATE SIGNED 7/13/82 | | | |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT) E. EDWARD FRANKO | | | 40. ADDRESS 2423 ARCADIA DR. EPO 21043 | | | | | | | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 42. DATE 7/16/82 | | | 43. NAME OF CEMETERY OR CREMATORY King Memorial Park | | | 44. LOCATION CITY OR TOWN COUNTY STATE Woodlawn MD | | |
| 45. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. | | | | | | 46. ADDRESS 1101 E. North Ave. | | 47. DATE REC'D. BY REGISTRAR JUL 15 1982 | | 48. REGISTRAR'S SIGNATURE Frances Jan Nathan | |

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|--|--|
| 1- STATE REGISTRAR Items #18a-22a MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 1 7 3 9 9 REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT (James Hayes Jr) BROOKS | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-12-82 | | 2b. HOUR 4:12 | | M | |
| 1. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 11 11 39 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 338 N. Bruce St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Hayes | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Selma Anderson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 217 78 1981 | | 17. INFORMANT ADDRESS Lucille Hayes 2241 W. Fayette St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | | DATE SIGNED 7-13-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson F.H. 1913 W. Balto. St. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|-------------------|--|--|--|--|---|----------|--|--|
| 1. FOR STATE REGISTRAR | | 7 2 1 7 4 0 0 | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| MILDRED A. BROPHY | | | | | | 7 12 82 | | | 7 10 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | |
| Female | | White | | MONTH 5 DAY 4 YEAR 10 | | 72 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | SOUTH BALT. GEN | | | | Homemaker | | --- | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 345 S. Smallwood Street | | 21223 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| George Limerick | | | | Mary Murray | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 219-03-0974 | | Mildred A. Rhodes | | 468 Colonial Ridge Lane | | 21012 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>FULMINANT BART FAILURE PULM EDEM</u> | | | | | | | | | | 10 DAYS | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>MITRAL VALVE INSUFF</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 6</u> , 19 <u>82</u> , to <u>July 12</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>July 12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| <u>M. McCarthy</u> | | | | | | | | 7/12/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| M. MCCARTHY | | | | 3001 S. HANOVER BALI | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| Burial | | 7/15/82 | | Baltimore National Cem. | | Baltimore | | COUNTY STATE Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME ADDRESS 21229 | | | | JUL 14 1982 | | <u>Thane J. [Signature]</u> | | | | | |
| Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | | | | | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 4 0 1
REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) BABY Girl Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR 6 20 82 | | | 2b. HOUR 957A _M | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 6 20 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 6 22 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balt. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 628 Pitcher St. 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Not Known | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL L. BROWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREVIABLE FETUS 7650 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/20 19 82 to 6/20 19 82 that (I) (we) last saw the deceased alive on 6/20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph Quinn MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 6/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH QUINN | | | | 22e. ADDRESS University Hospital, Baltimore Md. | | | |

| | | | | | | | |
|---|--|----------------------|--|------------------------------------|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR AUG 9 1982 | |

MEDICAL CERTIFICATION

29

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 4 0 2 REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bobbie Brown | | | | MONTH DAY YEAR 7/16/82 | | 7b. HOUR 5:15 PM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 12 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ga. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Denton Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | 13b. COUNTY Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 500 Archer St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Cheasmon | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Wooden | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-62-8529 | | 17. INFORMANT Daniel Brown | | ADDRESS 500 Archer St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cat cell carcinoma of lung metastatic (c) 5 months | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION 6/29 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29 , 19 82 , to 7/16 , 19 82 , that (I) (we) last saw the deceased alive on 7/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dana E. King | | | | DEGREE ATENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/16/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DE KING | | | | 22e. ADDRESS J.L. DEATON | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus mem. Pt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | | |



Female
G.A.

Black
N.A.

3 12 02

MD

Alfred

no

Belmont

Chesapeake

210-05-1000 Daniel Brown 200 Archer St

200 Archer St

Woodson

200 Archer St

Female 3/23/83 A. Prince with 200 Archer St

Mr. C. March 6/11/83 E. North 101 20th St

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17403 | |
|--|---------|---|--|--|--|--|--|--------------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Calvin L. Brown | | | | | | | | XX MONTH 7 DAY 15 YEAR 82 | | 19 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| male | black | 1 15 1944 | | 38 YRS. | | MONTHS DAYS | | HOURS MIN | | 7 15 19 82 1:05 PM | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY | |
| Md | | USA | | WIDOWED | | DIVORCED | | Baltimore city | | MD | |
| 11. CITY OR TOWN OF DEATH | | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 14. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Union Memorial Hospital | | | | | | | | | |
| 15. STATE | | 16. COUNTY | | 17. CITY OR TOWN | | 18. INSIDE CITY LIMITS? | | 19. STREET ADDRESS | | | |
| Md | | | | Baltimore | | YES X NO | | 1770 Montpelier | | | |
| 20. FATHER'S NAME | | 21. MOTHER'S MAIDEN NAME | | 22. INFORMANT | | 23. ADDRESS | | | | | |
| Calvin C. Brown | | Martha Dyson | | Martha Brown | | 1770 Montpelier | | | | | |
| 24. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 25. SOCIAL SECURITY NO. | | 26. INFORMANT | | 27. ADDRESS | | | | | |
| NO | | 212-40-2277 | | Martha Brown | | 1770 Montpelier | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES X NO | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner | | | | | | | | | | Autopsy X Inspection Inquiry and in my opinion | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | |
| Hormez R. Guard, MD. | | Assistant | | 7/16/82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | |
| Burial | | 7/20/82 | | Cedar Hill Cemetery | | Anne Arundel Co | | Md | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| William C. March F/H | | 1101 E. North Ave | | JUL 20 1982 | | James J. Van Natten | | | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 7 4 0 4

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Constance M. Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/7/82 | | | 2b. HOUR 3:35am | | | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 1 1918 | | 6 AGE (IN YEARS LAST BIRTHDAY) 63 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | |
| 10 CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) President Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1023 W 43rd St | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Nathaniel Brown | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Darnell Walker | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO | | | 17 INFORMANT Mrs Gwenidolyn Samuels | | | ADDRESS 1023 W 43rd Balto, Md | | | |

| | | | |
|--|--|---|--|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 1990 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18, 1982 to 7/7, 1982 , that (I) (we) last saw the deceased alive on 7/7, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |

| | | | | | | | |
|--|--|---|--|--|--|-----------------------------------|--|
| 21. SIGNATURE Janice I. Masi | | DEGREE MA | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janice I. Masi | | 22e. ADDRESS 1301 St. Paul Apt 84 Balto 21202 | | | | | |

| | | | | | | | |
|--|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (REGISTRY) Burial | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Balto, Gen. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md | |
| 24 FUNERAL DIRECTOR NAME Chatsnow #14 | | | | ADDRESS 1701 McCulloch St | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | |
| REGISTRAR'S SIGNATURE James J. Thacker | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. People may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 4 0 5 REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR BROWN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 24 82 | | | 2b. HOUR 1:45A _M | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 9 6 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH ALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 238-16-6259 | | 17. INFORMANT ADDRESS GLORIA BROWN 3024 TIOGA PARKWAY | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brainstem and cerebellar infarction</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe atherosclerosis, cerebral vasculature</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>July 17</u> , 19 <u>82</u> , to <u>July 24</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>July 24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>SA Henry, MD</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven A Henry, MD</u> | | | | | 22e. ADDRESS VAMC, Baltimore, Maryland 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL | | | 23b. DATE 7-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VET. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | | | | 1721 N. MONROE ST. | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | |

MEDICAL CERTIFICATION

9
9

BP

25b. DATE REC'D. BY REGISTRAR
JUL 28 1982

DATE: 11/11/11

TIME: 10:00

PAGE: 1

NAME: [illegible] NO. 12345

FROM: [illegible]
TO: [illegible]

DATE: 11/11/11

NAME: [illegible]
NO. 12345



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 0 6

REG. NO.

FOR
1. STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANORA E. BROWN | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 30 1982 | | 2b. HOUR 12:19p |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 8 15 19 | | 6. AGE (IN YEARS-LAST BIRTHDAY) 62 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Williams | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Delora Brown 13 W. Lee St. Belair, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pancreatic Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1579 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION 7/22/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pancreatic Cancer | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 82 , to 7/29 , 19 82 , that (I) (we) last saw the deceased alive on 7/29/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph Osterling MD | | | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Osterling | | | | 22e. ADDRESS Dept. of Surgery JH H | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Tabernacle Ch. Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | |
| ADDRESS 1101 E. North Ave. | | | | 25b. REGISTRAR'S SIGNATURE James J. Smith | |

MEDICAL CERTIFICATION

33
35
300
1

2
9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

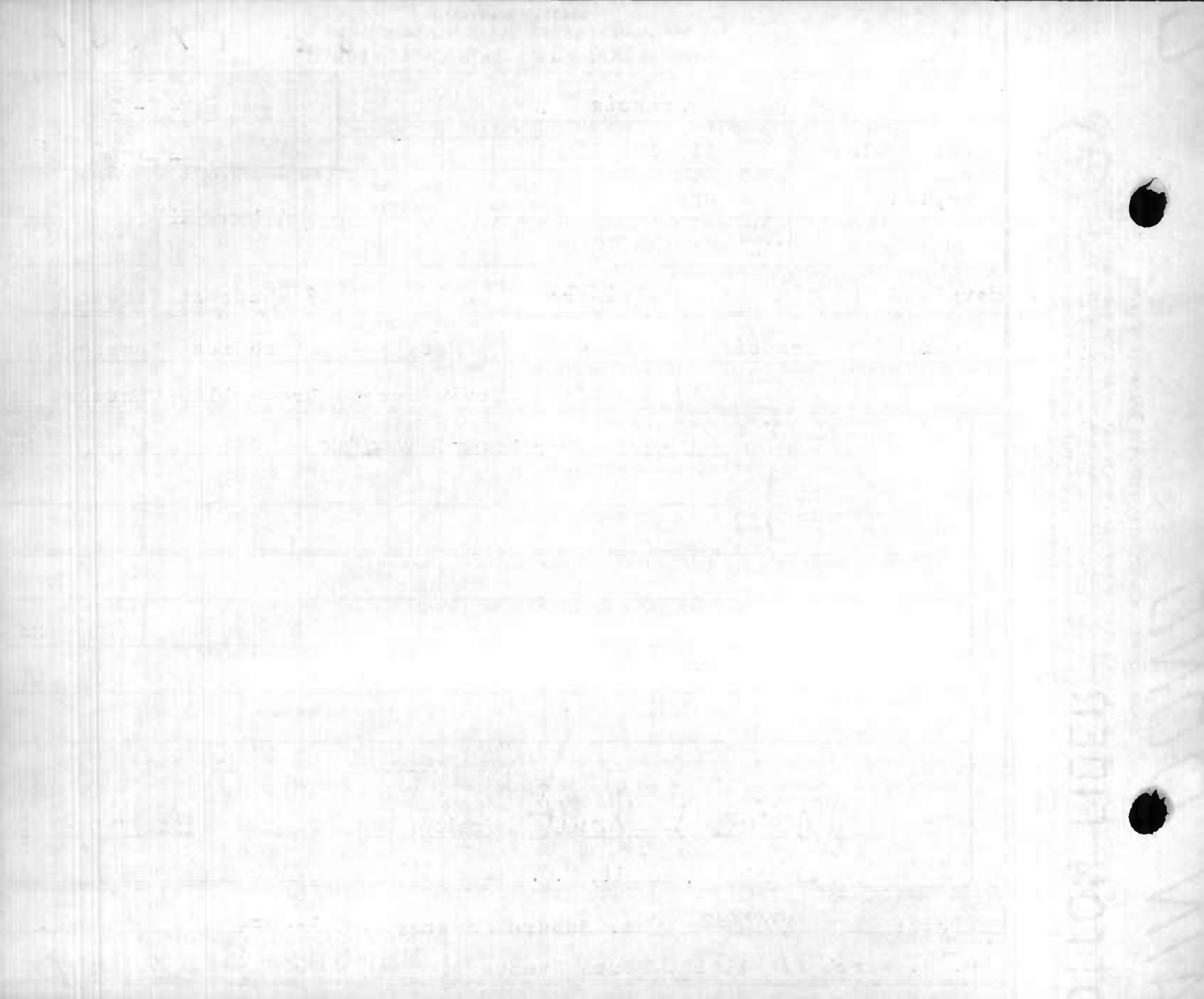
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ДЛЯ НАПРАВЛЕНИЯ
В РАЙОН



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH DEATH RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17407 | |
|--|--|------------------|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE Francis BROWN | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR XX 7-22-82 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 21 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 51 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD 8-2-82 19 | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1128 Whatcoat Street | | | |
| 12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13d. STREET ADDRESS 1128 Whatcoat Street | | | | 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Francis Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Veronica Dorsey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | | | 17. INFORMANT ADDRESS Irvin Jerome Brown 1126 Whatcoat St | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 8-3-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 8/7/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery | | | |
| 23d. LOCATION CITY OR TOWN Baltimore | | | | COUNTY | | | | STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 5 1982 | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 7 4 0 8 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Lonnie L. Brown | | | | | 2a. DATE OF DEATH MONTH 7 DAY 3 YEAR 82 | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH 11 27 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 605 Radnor Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 605 Radnor Avenue | |
| 14. FATHER'S NAME FIRST Seft MIDDLE Brown LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Nerva MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 245-18-1913 | | 17. INFORMANT ADDRESS Margaret Wicks 605 Radnor Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) 1850 DUE TO, OR AS A CONSEQUENCE OF (c) 1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1850 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1982 to May 1982 , that (I) (we) last saw the deceased alive on May 25 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Kevin R. Fox | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN R. FOX | | | | 22e. ADDRESS JDMHS HOPKINS HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Co. STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

1962-1963

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 3. YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17409 | |
|--|--|---------------------|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MAUDE V. BROWN | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 7-11-82 | | 2b. HOUR 9:00P | | 2c. DATE PRONOUNCED DEAD 7-11-82 | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1311 S. Hanover Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1311 S. Hanover Street | |
| 14. FATHER'S NAME FIRST Robert MIDDLE B LAST Brown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary Jane MIDDLE Woodfolk LAST Woodfolk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 218 01 8076 | | 17. INFORMANT Marcella Saunders | | | | ADDRESS S/A | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER DATE SIGNED 7-13-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-15-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvery Cem. | | | | 23d. LOCATION CITY OR TOWN Glen Burnie COUNTY A STATE MD | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F.H. | | | | | | ADDRESS 1913 W. Balto. St. | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | | |

UNITED STATES DEPARTMENT OF THE ARMY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 4 1 0 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Naomi Brown | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 19 82 | | | | |
| 3. SEX female | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 6 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | 7b. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1517 N. Carey St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service worker | | 12b. KIND OF BUSINESS OR INDUSTRY none | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1517 N. Carey St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Steven Brown | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Tubman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-1981 | | 17. INFORMANT ADDRESS Leon M. Brown 709 High Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Atrial Myocarditis DUE TO, OR AS A CONSEQUENCE OF (c) Dysphagia & Aspiration APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12 19 82 to 7/12 19 82 , that (I) (we) lost saw the deceased alive on 7/12 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert J. Williams | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. Williams | | 22e. ADDRESS 4200 EDMONSON AVE Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Boardley Home for Funerals | | | | ADDRESS Cambridge, Md. | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE Frances San Nathan | |



2025 OCT 10 10:00 AM

LIBRARY OF THE UNIVERSITY OF MICHIGAN

WASH. D. C. 20540

Mr. J. Edgar Hoover
Director
Federal Bureau of Investigation
Washington, D. C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

recently received information concerning the activities of the

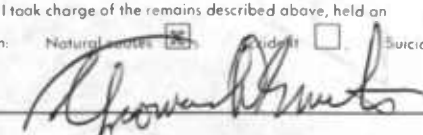
individuals mentioned in the letter of the 10th of the month.

I am sure that you will find this information of interest.

Sincerely,
[Signature]

Items #10a-22a Film G572 10/5/82 r STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|-------------------------|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Norman F. Brown Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 7 24 1982 | | 2b. HOUR M 6:06 P AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 10, 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) 34 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 24 1982 | | 7d. HOUR M 6:06 P AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 519 W. 28th Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Norman F. Brown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gladys Smallwood | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 220 50 2658 | | | | 17. INFORMANT ADDRESS Joyce McCorkle 3102 Sixth Street 21234 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Intravenous narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural <input checked="" type="checkbox"/> , Accidental <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER | | | | | | | | DATE SIGNED 7/25/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/27/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mays Chapel Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Balto Md | | | |
| 24. FUNERAL DIRECTOR NAME Burgess Funeral Home | | | | | | ADDRESS 3631 Falls Road 21211 | | | | 25a. DATE REC'D. BY JUL 28 1982 | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| 2- 1 7 4 1 2 | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL W. BROWN | | | | | 2a DATE OF DEATH MONTH DAY YEAR July 7/6/82 1982 | | | | | 2b HOUR 2350 |
| 3 SEX Male | | 4 RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 7 15 09 | | 6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 72 | | IF UNDER 24 HRS. HOURS MIN. 72 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10 CITY OR TOWN OF DEATH BAAT. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Wilbert Brown | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Kate | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT Russell W. Brown, Jr. Bronx, N.Y. | | ADDRESS 1906 Adees Ave. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE 4360 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE CVA's APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE David L. Yin | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/6/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID L. YIN, MD | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 07/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEM | | 23d. LOCATION CROWNSVILLE COUNTY Md. STATE | | | | |
| 24. FUNERAL DIRECTOR MARSHALL W JONES, JR/4101 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE Anna J. [Signature] | | | |

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2000

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1202 BP
DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 4 1 3 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| FOR 1. STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) William E. Brown | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 12, 1982 | | | 2b. HOUR 8:30A^M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 2 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS HOURS MIN. MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH FACILITY, GIVE STREET ADDRESS) 2930 Greenmount Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plasterer | | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William M. Brown | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie B. Wilson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 05 9751 | | 17. INFORMANT ADDRESS Doris M. Robertson 5315 Forge Rd. White Marsh, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4140 Possible Coronary Heart Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR May 3, 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) June 26, 1982 | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 449 E. 25th Street, Baltimore, Md. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 26, 1982 to June 26, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE MD | | | 22c. DATE SIGNED July 12, 1982 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alphonse Y.S. Rhee | | | | | | 22e. ADDRESS 449 E. 25th Street, Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balto Co. Md | | | |
| 24. FUNERAL DIRECTOR Burgess Funeral Home 3631 Falls Road Baltimore, Md. 21211 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 14 1982 James J. Nathan | | | | | |

MEDICAL CERTIFICATION



William J. Brown
 2030 Greenmount Avenue
 Baltimore, Md.
 July 12, 1962

To
 Mr. William J. Brown
 2030 Greenmount Avenue
 Baltimore, Md.

Mr. William J. Brown
 2030 Greenmount Avenue
 Baltimore, Md.

William J. Brown
 2030 Greenmount Avenue
 Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 1 4

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | JULY 7 9 1982 | | 9:43A M | |
| 3. SEX Male | | 4. RACE NEGRO | | 5. DATE OF BIRTH 7 23 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. | | 12a. USUAL OCCUPATION (TYPE AND CLASS FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY BETH STEEL | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME CHARLES | | 15. MOTHER'S MAIDEN NAME HATTIE | | 16. STREET ADDRESS 264 N. HILTON ST. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 231-14-0549 | | 17. INFORMANT CALLIE L BROWN/264 N. HILTON ST. | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) HYPERTENSION. DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/7/1982, to 7/9/1982, that (I) (we) last saw the deceased alive on 7/9/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE N.S. ASHOK | | DEGREE | | 22c. DATE SIGNED 7/ | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) N.S. ASHOK | | 22e. ADDRESS Lutheran Hospital | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTO Md. | |
| 24. FUNERAL DIRECTOR MARSHALL W JONES, JR /4101 | | 25a. DATE RECD. BY REGISTRAR JUL 12 1982 | | 25b. REGISTRAR'S SIGNATURE D. W. Nathan | | | |



7
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17415 | |
|--|--|----------------------|--|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Margaret C. Bryan | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 7 DAY 15 YEAR 82 | | 2b. HOUR 6:30 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 8 DAY 23 YEAR 1914 | | 6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH 7 DAY 15 YEAR 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH PM Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hsp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY --- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3548 Fourth St., 21225 | | |
| 14. FATHER'S NAME FIRST Unknown MIDDLE LAST Cook | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 231-16-8075 | | 17. INFORMANT John Bryan, Jr. ADDRESS 8621 Drumwood Road, Towson, Md. 21204 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7/15/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/19/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | | 23d. LOCATION CITY OR TOWN Elkridge, Howard Co., Md. COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home ADDRESS Balto., Md., 21225 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |

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LIBRARY
UNIVERSITY OF ALABAMA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 4 1 6
CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah Moore Bryant | | 2a. DATE OF DEATH MONTH DAY YEAR 7/25/82 | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 10/31/27 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 7b. HOUR M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY Balto | 13c. CITY OR TOWN Balto |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2507 Riggs Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James E. Torney | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Torney | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 206-14-4239 | |
| 17. INFORMANT ADDRESS McCleavem Bryant 2507 Riggs Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4100 DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE RABerg | | 22c. DATE SIGNED 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RABerg | | 22e. ADDRESS Suite 400, 711 W 40th St, Balt 21211 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/30/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Garden Ent. Hope | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pinksburg Md. | |
| 24. FUNERAL DIRECTOR NAME Chas A Rice 1300 Eutaw Place. | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | |
| 25b. REGISTRAR'S SIGNATURE James Van Natten | | | |

IMC 6

0 192 35 01

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 7 4 1 7

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Melvin Edward (John) BRZUCHALSKI | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 24 82 | | 2b. HOUR 9:10 ^{AM} |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1926 | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lic. Examiner | 12b. KIND OF BUSINESS OR INDUSTRY State of MD. | |
| 13a. STATE Maryland | 13b. COUNTY A.A. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 407 Second Avenue S.W. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter Brzuchalski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Karwacki | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 11 219.16.2723 | 17. INFORMANT (Wife) ADDRESS Mrs. Florence L. Brzuchalski Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>squamous cell carcinoma of lung</u> 30 months DUE TO, OR AS A CONSEQUENCE OF (c) <u>Remains primary</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION 7/8/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED tracheal obstruction | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> 19 <u>82</u> to <u>7/24</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive <u>7/23</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) did not view the body after death. | | | | | |
| 22b. SIGNATURE <u>Ira Tapel, MD.</u> | | DEGREE M.D. | | 22c. DATE SIGNED 7/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Tapel, MD. | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 28 July 82 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A.A., MD. |
| 24. FUNERAL DIRECTOR NAME Singleton Funeral Home | | ADDRESS Glen Burnie, MD. | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 1 8
REG. NO.

| | | | | | |
|--|------------------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GILBERT A BUCHANAN | | 2a. DATE OF DEATH MONTH DAY YEAR 7 1 82 | | 2b. HOUR 3 25 PM | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 4/19/18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | |
| 7a. BIRTHPLACE (COUNTRY) VA. | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) truck driver | |
| 13a. STATE MD. | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN MIDDLE RIVER | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BUCHANAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERNA COX | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNK | | 16b. SOCIAL SECURITY NO. 228 031356 | | 17. INFORMANT ADDRESS KATE BUCHANAN ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5990 IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown Tract Infection DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Respiratory Failure, Respiratory Acidosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/16/82, 1982, to 7/1/82, 1982, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE H. A. [Signature] | | DEGREE | | 22c. DATE SIGNED 7/1/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hacib Aoun | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | 24. FUNERAL DIRECTOR NAME ADDRESS J.G. CONNELLY 300 MACE | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JUL 7 1982 Francis J. VanNathan | | | |

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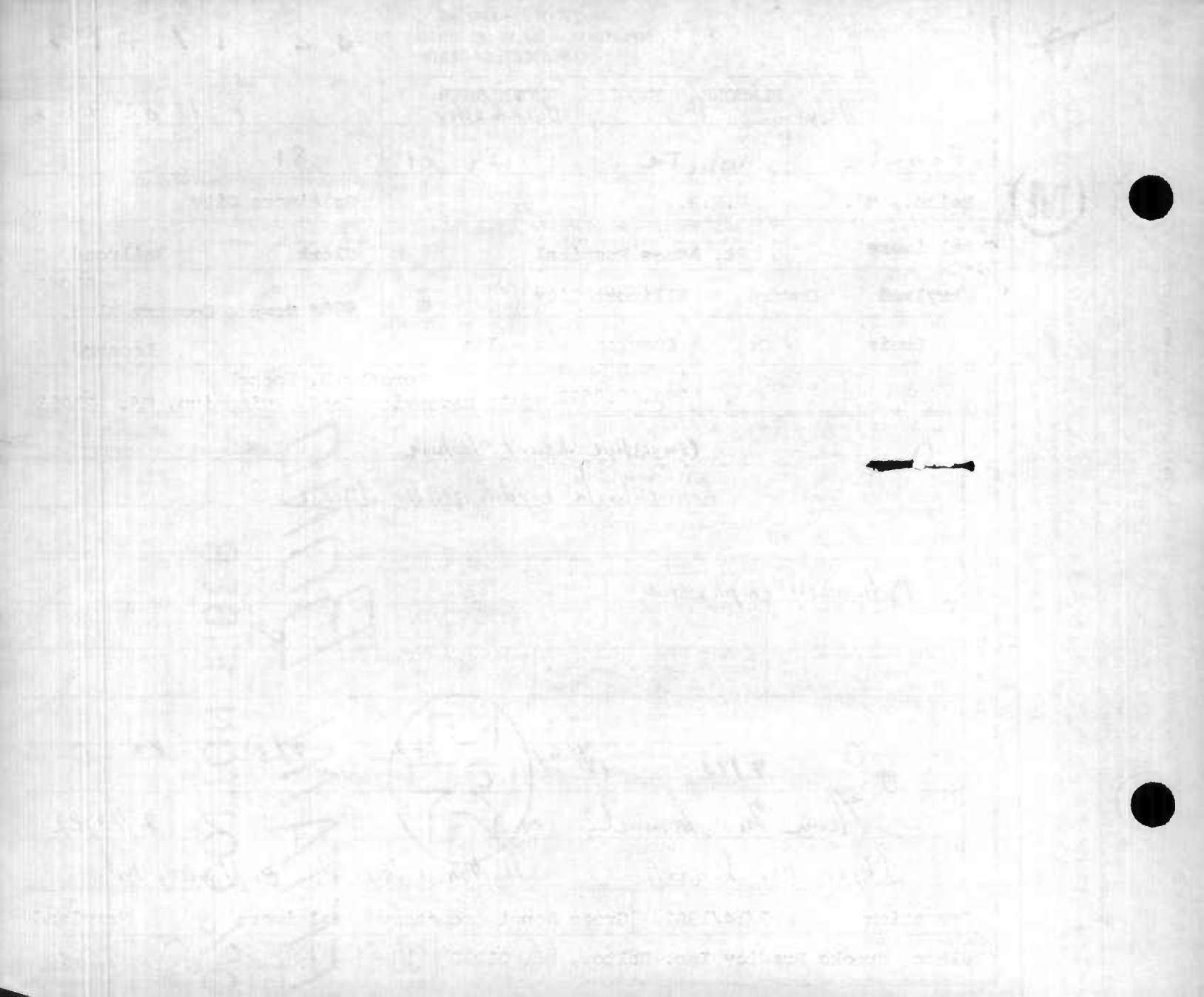
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 4 1 9 | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} HELEN ^{MIDDLE} BLANCHE ^{LAST} BUGGLEN BUCKMASTER <i>Helen B Buckmaster</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>1 29 01</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>81</i> | | IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Agnes Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <i>Maryland Howard Ellicott City</i> | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS <i>8904 Town & Country Blvd. 21043</i> | | | | | |
| 14. FATHER'S NAME ^{FIRST} Louis ^{MIDDLE} C. ^{LAST} Bugglen | | | | 15. MOTHER'S MAIDEN NAME ^{FIRST} Ida ^{MIDDLE} ^{LAST} Leonard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>705.05.2633</i> | | 17. INFORMANT ADDRESS <i>Dorothy B. Roesch 2412 Ravenview Road Timonium, Md. 21093</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary emphysema</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Pulmonary emphysema</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>7/6/82</i> to <i>7/13/82</i> , that (1) (we) last saw the deceased alive on <i>7/13/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Steven M. Samuels</i> | | | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>7/13/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Steven M. Samuels</i> | | | | 22e. ADDRESS <i>St. Agnes Hospital, Baltimore, Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>7/14/1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount Crematory</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Walter Brooks Bradley Inc. Balto., Md. 21222</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 19 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Frances Jean Wether</i> | | | |



BUGATCH, BENJAMIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The low required death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-1650M/1/B1
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 4 2 0 | |
|---|-----------------|--|--|---|--|
| 1. STATE REGISTRAR | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) BENJAMIN BUGATCH | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 24 1982 | | 2b. HOUR 4:54p | |
| 3. SEX MALE | 4 RACE WHITE | 5 DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY INSTALLMENT HOUSE | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 13a. STATE MARYLAND | |
| 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM BUGATCH | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL UNKNOWN | | 16. STREET ADDRESS 6900 FIELDCREST RD. #21215 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 578-10-2860 | | 17. INFORMANT MRS. MADELINE PAUL 6706 PARK HTS. AVE. BALTO., MD 21215 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>? sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 7/10 to 7/24 1982, that (I) (we) last saw the deceased alive on 7/24 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE H. Parkman | |
| 22c. DATE SIGNED 7/24/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PARKMAN | | 22e. ADDRESS Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MARYLAND | | 24 FUNERAL DIRECTOR NAME Sol Lewinson | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | |
| 25b. REGISTRAR'S SIGNATURE Name of Registrar | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 4 2 1 REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIVE B. BURCH | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/11/82 | | 2b. HOUR 1A M | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 19, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book-keeper | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Phoenix | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 4309 Green Glade Rd. 21131 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ulyses Grant Blacksten | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha I, Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | 16b. SOCIAL SECURITY NO. 216-10-8648 | | 17. INFORMANT ADDRESS Mrs. Hazel R. Cordray, same as #13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: 5109 IMMEDIATE CAUSE (a) Perforated Cecocolic Empyema Rt. Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION 6/14/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Malnutrition | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/6/82, 1982, to 7/4/82, 1982, that (I) (we) lost saw the deceased alive on 7/10 midday 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. M. Rashid MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RASHID M. RASHID | | | | 22e. ADDRESS Union Memorial Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore county Maryland | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 12 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | |

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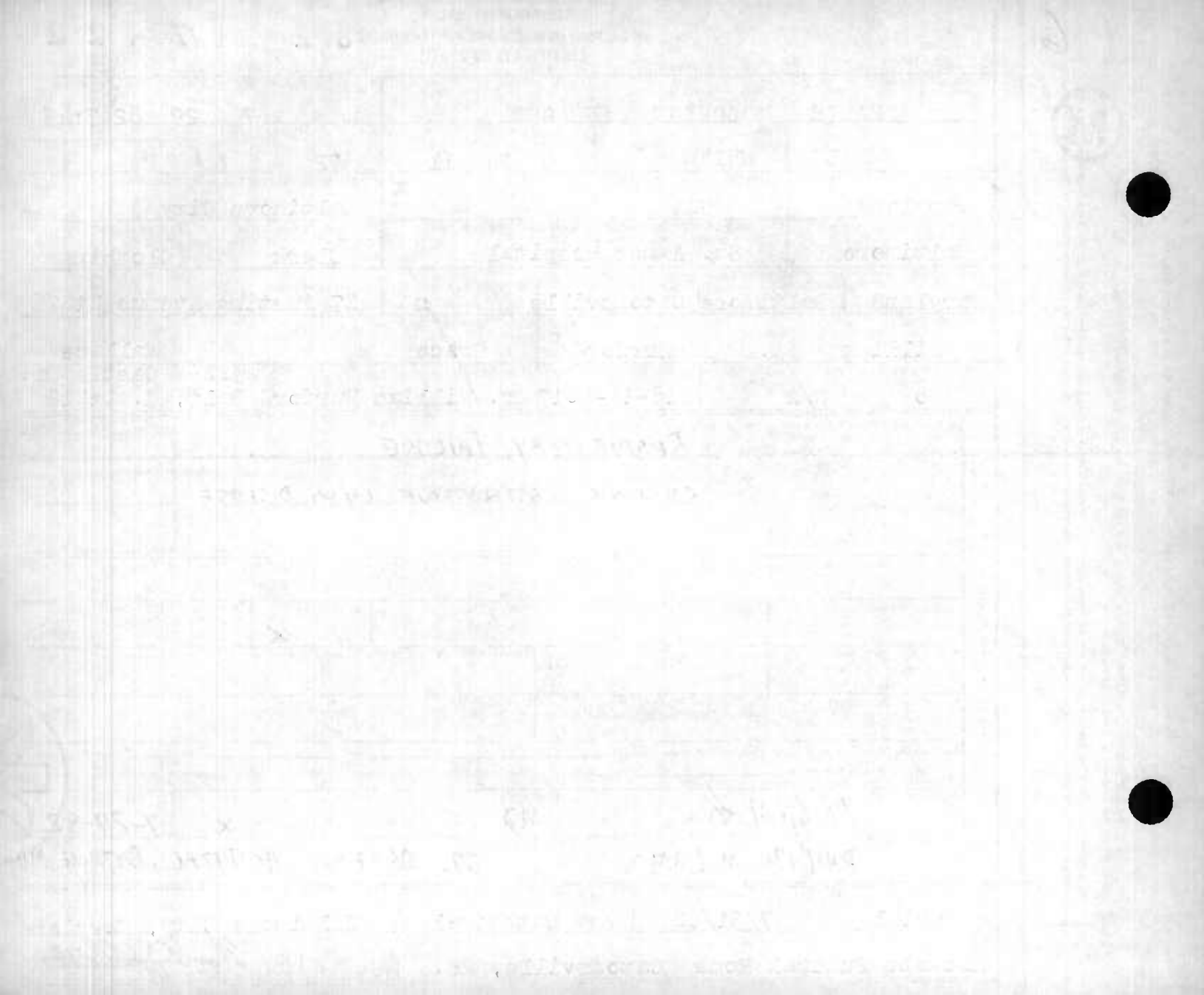


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|--|--|----------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7 2 1 7 4 2 2 CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | |
| MARIE LOUISE BURFORD | | | | | 7 29 82 7:45 AM | | | | | |
| 3 SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 6 24 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Clothing | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. Burford | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Wallace | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A | | 17. INFORMANT ADDRESS 522-F Castle Dr. Mr. William Burford Balt, Md. 21212 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Philip M Lam | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-29-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP M LAM | | | | 22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home | | | | ADDRESS Catonsville, Md. | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LOUVENIA (LAVENIA)

A.

BURGESS

2a. DATE KNOWN
OF DEATH ESTI-
MATED

MONTH DAY YEAR

2b. HOUR

7 4 19 82

M

3 SEX
Female4 RACE
Black5 DATE OF BIRTH
MONTH DAY YEAR
6 5 566. AGE (IN YEARS
LAST BIRTHDAY)
26 YRS.IF UNDER 1 YR.
MONTHS DAYSIF UNDER 24 HRS.
HOURS MIN2c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
7 4 19 822d. HOUR
7:36
AM7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
S.C.7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH
Baltimore11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Johns Hopkins Hosp. (DOA)12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRYUSUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY13c. CITY OR TOWN
Baltimore13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS
2232 Walbrook Avenue14. FATHER'S NAME
FIRST MIDDLE LAST
Odell Burgess15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rosa B. Hannah16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
N/A17. INFORMANT ADDRESS
Rosa Burgess 2232 Walbrook Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

4290

IMMEDIATE CAUSE (a) Non-specific myocarditis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Ann M. Dixon, M.D.

TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINERDATE
SIGNED 7-5-8223a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE
7/8/8223c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem.23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Co. MD24. FUNERAL DIRECTOR
NAME

Wm. C. March F/H 1101 E. North Ave.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JUL 6 1982

Name Jan. Martin

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST.,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.DHMH - 17
(VR A15 ME (5))
20M 4/82

UNCLAS

100
25

Handwritten signature or initials



6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

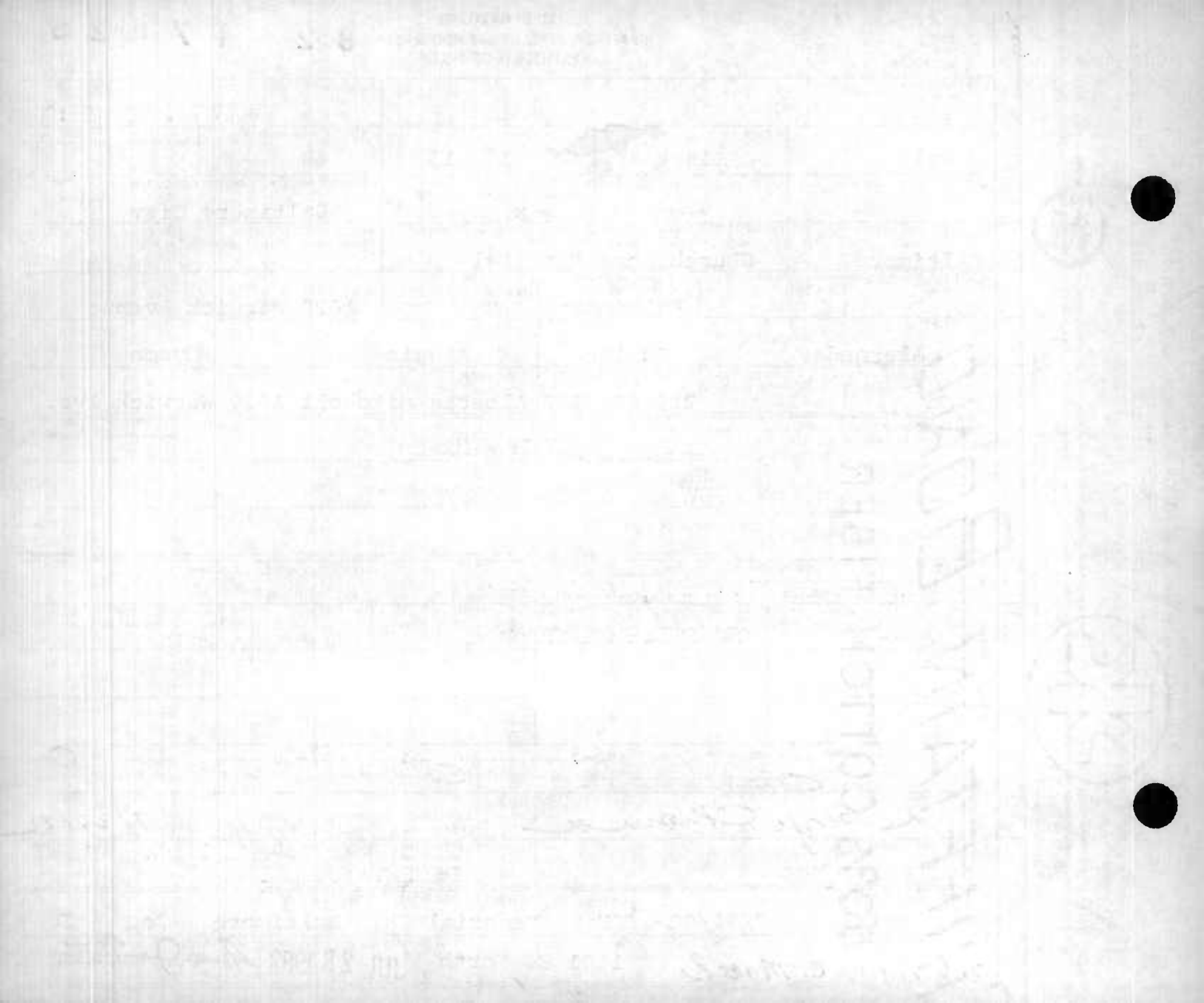
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 4 2 4 | |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thelma E. Bussmann | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-29-82 2b. HOUR 5:30 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 29, 1908 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. CITY OR TOWN Brooklyn | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jesse Winebrenner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Madden | | 13c. STREET ADDRESS 311 14th Ave. 21225 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-74-7328 | | 17. INFORMANT ADDRESS Mr. Bernard Bussmann Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Cardiac arrest 2nd to arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Large Decubitus Ulcer | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 10, 1919 to 7/29, 1982 , that (I) (we) last saw the deceased alive on 7/28, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Samuel Rubin M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL RUBIN | | | | 22e. ADDRESS 1 Slade Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery | |
| 24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Brooklyn | | 24b. ADDRESS 237 E. Patapsco Ave., Balto., Md. 21225 | | 24c. DATE REC'D. BY REGISTRAR AUG - 3 1982 | |
| 24d. REGISTRAR'S SIGNATURE Kenneth J. Nathan | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director for 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 2 | 1 | 7 | 4 | 2 | 5 |
|--|--|---|--|--|---|--|--|---|--|--|---|--|---|----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH H. BUTLER | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 82 | | | | 2b. HOUR 11:00pm | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 10 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. IF UNDER 24 HRS. HOURS MIN. 0 0 | | | | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | | | | |
| 11. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1620 Warwick Avenue | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Butler | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Dyson | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-05-8202 | | 17. INFORMANT ADDRESS Alberta Mitchell 1620 Warwick Ave. | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED CARCINOMA COLON DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1539 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7-12-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRANSVERSE COLOSTOMY | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-18 , 19 82 , to 7-26 , 19 82 , that (I) (we) last saw the deceased alive on 7-26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE K. George Thomas | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/26/82 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE THOMAS | | | | | | 22e. ADDRESS CHURCH HOME HOSPITAL 100 N. BROADWAY BALTIMORE MARYLAND 21231 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. Match | | | | ADDRESS 1101 E. North | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | | | | |



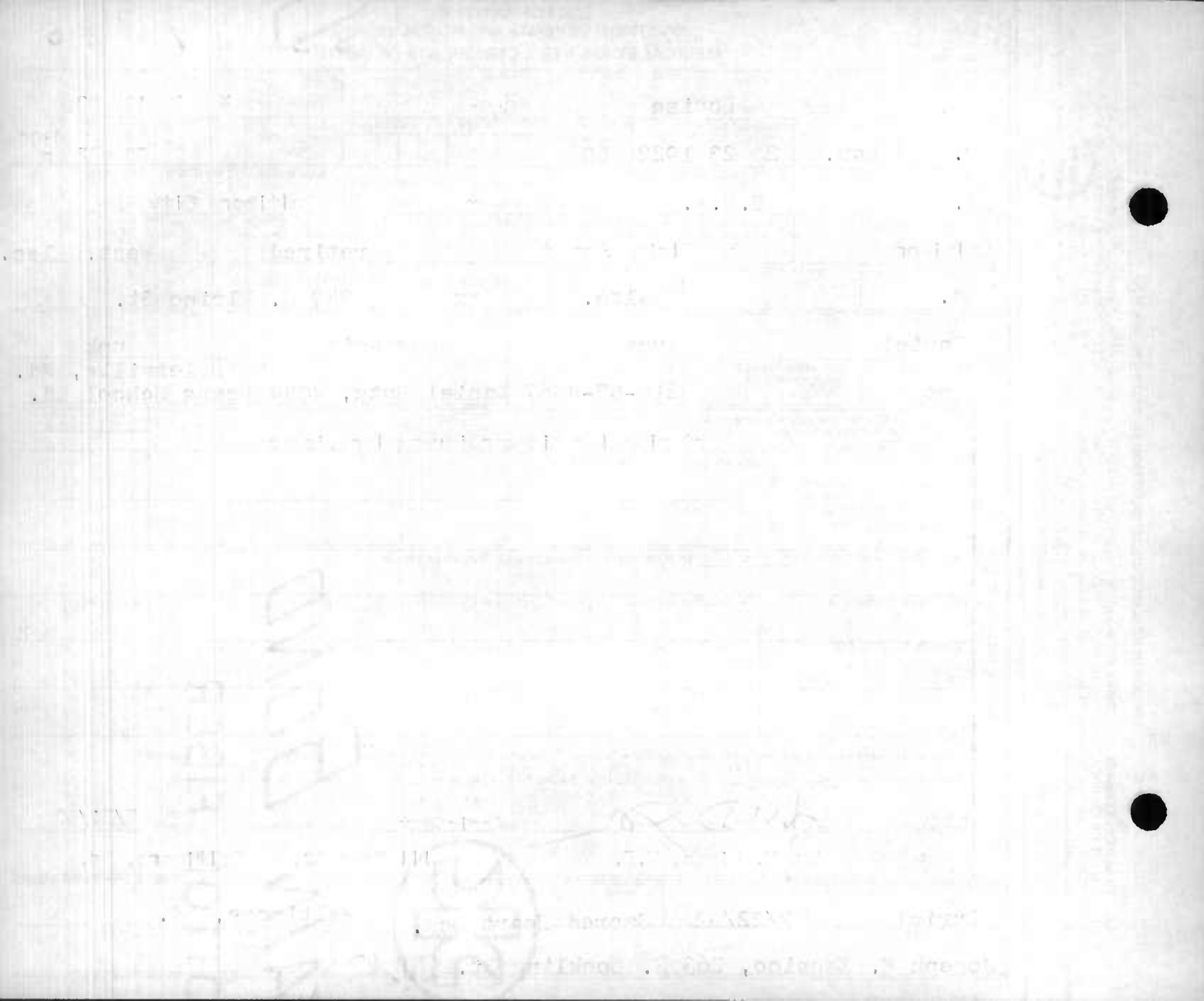
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE SUBMITTED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|--|---------|---|--|---|--|-----------------------------------|--|--|--|--------------------------|--|-------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | KNOWN OF ESTI-MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Anna Louise Butz | | | | | | | | 7 | | 19 | | 82 | | | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| F. | Cau. | 2 23 1922 | | 60 YRS. | | | | | | 7 | | 20 | | 82 | | | | 4:04 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Md. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, | | | | | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 349 Elrino Street | | retired | | West. Elec. | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md. | | | | Balto. | | YES NO | | 349 S. Elrino St. | | | | | | | | | | | |
| 14. FATHER'S NAME | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | MIDDLE | | LAST | | | | | | | | | |
| Daniel | | | | Kunak | | Anastasia | | | | unk | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| no | | 218-07-4367 | | Daniel Butz, | | 4044 Heaps School Rd. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 4292 | | Arteriosclerotic cardiovascular disease | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| | | (c) | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES | | NO | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: | | Autopsy | | Inspection | | Inquiry | | and in my opinion | | | | | | | | | | | |
| Natural causes | | Accident | | Suicide | | Homicide | | Undetermined manner | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Ann M. Dixon | | Assistant | | 7/21/82 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St. | | Baltimore, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | 7/22/82 | | Sacred Heart Cem. | | Baltimore, Md. | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Joseph N. Zannino, | | 263 S. Conkling St. | | | | JUL 22 1982 | | | | | | | | | | | | | |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17427 | |
|--|--|---------------------|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Johnnie JOHNNY Robert CAIN Jr. | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-5-82 19 | | 2b. HOUR M 8:07 P | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 9 26 45 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 36 | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3601 Oakmont Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Johnnie Robert Cain | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phosa Cain | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214 44 4587 | | 17. INFORMANT ADDRESS Phosa Cain 3601 Oakmont Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9660 IMMEDIATE CAUSE (a) Stabwound of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7:30PM 7-5-82 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) subject stabbed | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4900blk. Denmore Avenue Balto., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-6-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson F.H. 1913 W. Balto. St, | | | | | | 25a. DATE REC'D BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Harrison</i> | | | |



UNCLASSIFIED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 2 8

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Genevieve (Geneieve) M. Calhoun | | 2a. DATE OF DEATH MONTH DAY YEAR 07/29/82 | | 2b. HOUR 4:15 PM | |
| 3 SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 28 03 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 903 N. Wolfe Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Shipley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Gould | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 217-22-6232 | | 17. INFORMANT Pauline Knotts ADDRESS 717 Druid Park Lake Dr | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4360

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Stroke**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Coronary Heart Disease**

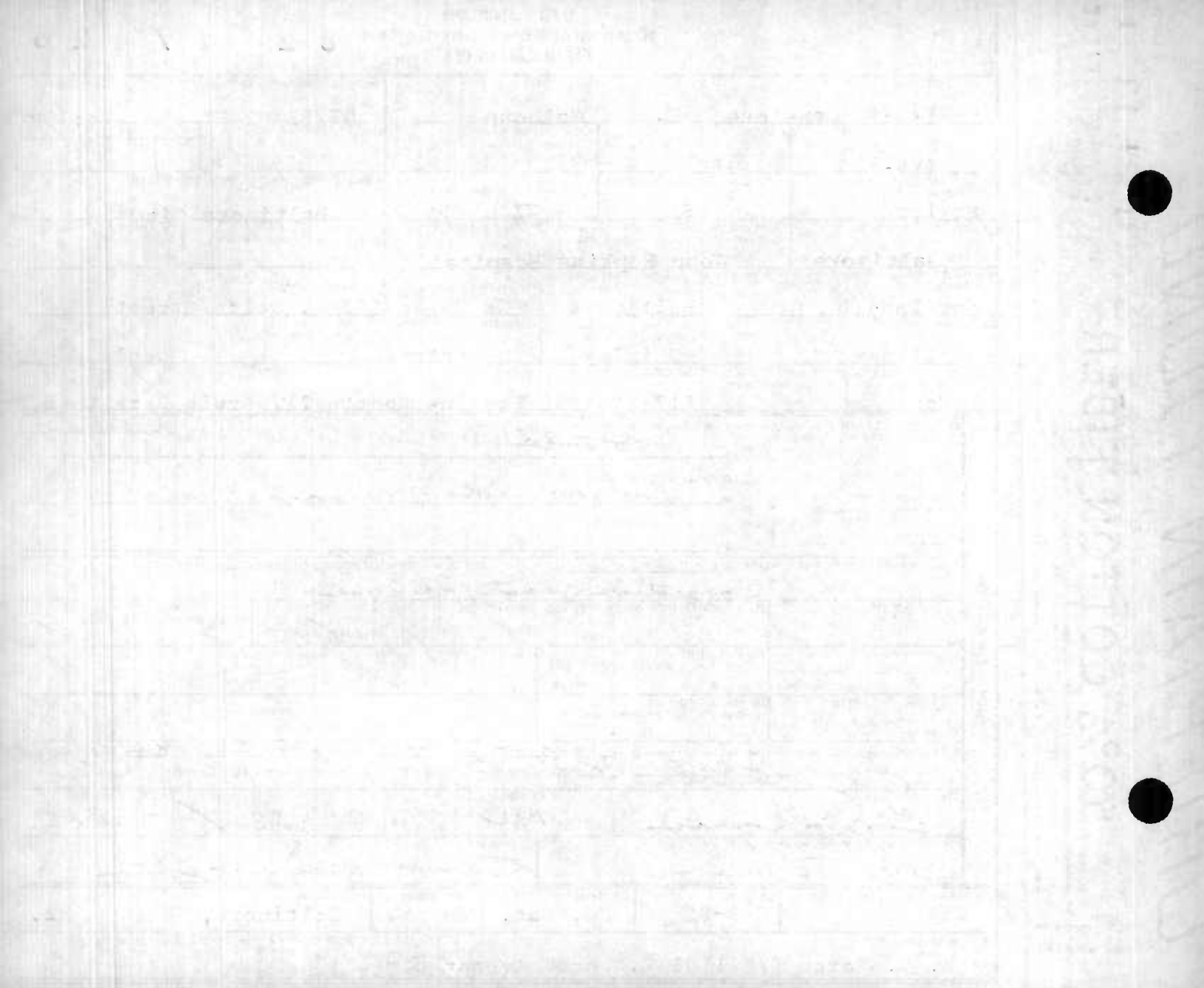
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

Coronary Heart Disease

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 29 , 19 82 , to July 29 , 19 82 , that (I) (we) lost saw the deceased alive on July 29 , 19 82 , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Eric Johnson | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Johnson | | 22e. ADDRESS John Hopkins Hospital | | | | | |

| | | | | | | | |
|---|--|----------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE 8-3-82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE James Van Natter | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 4 2 9
CERTIFICATE OF DEATH

| | | | |
|---|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH F. CAMPBELL | | 2a. DATE OF DEATH MONTH DAY YEAR 7 20 82 2b. HOUR 9:10P M | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH MONTH DAY YEAR 10-23-1923 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER |
| 12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. COUNTY — | 13c. CITY OR TOWN BALTO |
| 14. FATHER'S NAME FIRST MIDDLE LAST BURT CAMPBELL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TULULAH MOORE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. W.W. II 249-42-5368 | 17. INFORMANT ADDRESS Mrs. Mary A. Campbell - 1823 Ramsay St. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ischemic bowel</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (X) (this hospital) attended the deceased from June 9, 1982, to July 20, 1982, that (X) (we) lost saw the deceased alive on July 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Robert J. Schloeger, M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Schloeger, M.D. | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore, Md 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-26-82 | 23c. NAME OF CEMETERY OR CREMATORY CROWNSTOWN VET. |
| 23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSTOWN, MD. | | 23e. DATE REC'D. BY REGISTRAR JUL 23 1982 | |
| 24. FUNERAL DIRECTOR NAME Hartley Miller - 7527 | | 24b. REGISTRAR'S SIGNATURE James Van Natten | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 4 | 3 | 0 |
|--|--|--|---|--|---|--|--|--|---|--|---|-----------------------------|---|--------------------------------------|---|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. 75-70-01 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROGER O. CANNON, SR | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-28-82 | | | | 2b. HOUR 10¹⁴ P.M. | | |
| 3. SEX male | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH MONTH DAY YEAR 09 13 20 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Delaware | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MIEMSS - UNIV OF MD HSP | | | | | | | 12a. USUAL OCCUPATION (TYPE WORK FOR EMPLOYER) Construction | | | 12b. KIND OF BUSINESS OR INDUSTRY Worker | | | |
| 13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) STATE Delaware | | | 13b. COUNTY N.C. | | 13c. CITY OR TOWN Odessa | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 293 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lawrence V. Cannon | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Mae Whitlock | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 221-14-8808 | | | | | 17. INFORMANT ADDRESS Joan M. Cannon - Odessa, Del. | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4416 IMMEDIATE CAUSE (a) CARDIAC ARREST, MYOCARDIAL INFARCTION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE RUPTURED AORTIC ANEURYSM (AAS) | | | | | | | | | | 1-2 HOURS | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HISTORY OF CORONARY ARTERY BYPASS GRAFTING, NUCVD | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 0 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ above, (I) (we) (did) (did not) view the body (anatomical). | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE J. Lawrence Fitzpatrick M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/28/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.L. Fitzpatrick | | | 22e. ADDRESS Univ of MD Hospital Dept of Surgery | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8/2/82 | | | 23c. NAME OF CEMETERY OR CREMATORY Forest Cem. | | | 23d. LOCATION Middletown - N.C. Del. | | | | | | | |
| 24. FUNERAL DIRECTOR Robert C. Hutchinson - Middletown, Del. | | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | | 25b. REGISTRAR'S SIGNATURE James J. Matthews | | | | | | | | | | |

ROGER O. CANNON, JR. 11-28-85

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Barman's Day

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. ~~Signatures~~ may be retained by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 4 3 1 REG. NO. | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLA LOUISE CANZANI | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 9, 1982 | | | | 2b. HOUR 8:45 PM | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS. HOURS MIN. MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Plumbing | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1700 Meridene Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Bain | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Mamby | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-01-7757 | | 17. INFORMANT ADDRESS Stephanie DiPaula, 3427 Northway Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Liver failure DUE TO, OR AS A CONSEQUENCE OF (b) Carbosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) 342 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2mo | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/6 19 82 to 7/9 19 82 that (I) (we) last saw the deceased alive on 7/6 19 82 and that in (my) (our) opinion death occurred on the 9 day and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Norman R. Freeman, Jr., M.D. | | | | | | DEGREE MD | | 22c. DATE SIGNED July 12, 1982 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman R. Freeman, Jr., M.D. | | | | | | 22e. ADDRESS 11 W. 29th St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE July 12, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214 | | | | | | 25a. DATE REC'D. BY REGISTRAR (25). REGISTRAR'S SIGNATURE JUL 12 1982 Frances San Nathan | | | | | |

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2



| THELMA CAPPERELLA | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 7 4 3 2 | |
|---|--|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | REG. NO. | |
| THELMA V. CAPPERELLA | | | | 07 19 82 | | 7:40 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | | CAUC. | | 4/5/27 | | 55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD. | | U.S. | | | | BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | RETIRED | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MD. | | | | BALTO. | | 836 POWERS ST. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| ? ? ? | | | | ? ? ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | | | | | SON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) Metastatic small cell CA | | | | | | | |
| 1991 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/18 19 82 to 7/19 19 82 that (I) (we) last saw the deceased alive on 7/18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| BRIAN H. KAHN, M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| BRIAN H. KAHN M.D. | | | | UNION MEMORIAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 7/22/82 | | LAKEVIEW | | CARROLL MD. | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REC'D. BY | | | |
| Paul E. Chomkowski 3617 Chestnut Ave. | | | | JUL 26 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8 2 1 7 4 3 3 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Harriet E Carey | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/17/82 | | | 2b. HOUR M | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3/27/1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Howard Co. MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3030 Poplar Terrace 21216 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cafeteria Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 3030 Poplar Terrace 21216 | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Rheubottom | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Gassaway | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, FID OR UNFID ()) (IF YES, GIVE WAR OR DATES) - - - - - 0 - - - - - | | | 16b. SOCIAL SECURITY NO. 219-20-6287 | | 17. INFORMANT ADDRESS 21216 Osa Wainwright, 3026 Poplar Terrace | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Massive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension; Degenerative Arthritis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-17-82 5-years - | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/23/82 19 to 6/30/82 19, that (I) (we) last saw the deceased alive on 6/30/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. Bradshaw Higgins | | | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22d. DATE SIGNED 7/19/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Bradshaw Higgins | | | | | 22f. ADDRESS 3243 Madison Ave. Baltimore, Md. 21217 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Western Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Law Funeral Home 4611 Park Heights Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 4 3 4 | | | |
|---|--|---|--|---|--|--|--|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Augusta Carlson | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 18 82 | | | | | | | 2b. HOUR 6 45 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11 14 84 | | 6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS | | | IF UNDER 1 YEAR MO. DAYS HOURS MIN. | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Federal Hill Nursing Center | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1706 Charlotte Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Milas | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 214-74-2083 | | 17. INFORMANT ADDRESS Records - 1213 St. Light St | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4241 IMMEDIATE CAUSE (a) Cardiac arrest 2° DUE TO, OR AS A CONSEQUENCE OF (b) Aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c) arthritis + deafness PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) and right broken hip | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/7/82, 19 to 7/18, 19 82, that (I) (we) last saw the deceased alive on 7/16, 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Samuel Ruben | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 7/19/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL RUBEN | | | | | 22e. ADDRESS 1 SHADE AVE | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 7/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nithen | | | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | ITEM 13e Phone on | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 7 2 1 7 4 3 5 | |
|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR | | 7-12-82 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | | LAST | |
| Daniel | | | | Carr | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | |
| Male | | Black | | 4-17-26 | | 56 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore, Md. | | U.S.A. | | | | Baltimore City | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 444 Manse Court | | Unemployed | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | | Baltimore | | 444 MANSE CT | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| Daniel | | Mary | | No | | 218-42-4318 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| Mary Parker | | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | |
| | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22b. DATE | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | 7-8-82 | | MT. AUBURN | | Baltimore MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7-8-82 | | MT. AUBURN | | Baltimore MARYLAND | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE REC'D. BY REGISTRAR | |
| William J. Spicer | | 8 1982 | | Frances Van Kester | | | |

7-13-63
7-13-63

DATE: 7-13-63

TIME: 10:00 AM

LOCATION: [illegible]

PERSONNEL: [illegible]

STATUS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

REMARKS: [illegible]

TO: [illegible]

TO: [illegible]

FROM: [illegible]

100-100000

100-100000



7-13-63

7-13-63

7-13-63

7-13-63

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8217436 | |
|--|-------------------------|---|--|---|--------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jermaine Evangelist Carr | | | | | | 2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 7 8 19 82 | | 2b. HOUR 5:45 PM | | | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 81 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 1 | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 8 19 82 | | 7d. HOUR 5:45 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Carr | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miley Price | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Miley Carr 1224 Ensor St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7981 IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H. Guard</i> | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7/9/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD | | | | ADDRESS 111 Penn Street, Balto. MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>James Van Natten</i> | | | |



5 2010

Handwritten scribbles and marks, possibly initials or a signature.

3 Copies

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2533 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be related by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

item 23c-d #G569 7/13/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 7 2 1 7 4 3 7

| | | | | | | | |
|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GUY H. CARROLL | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 4 82 | | | 2b. HOUR 12 42 A M | |
| 3. SEX M | 4. RACE C | 5. DATE OF BIRTH MONTH DAY YEAR 11 29 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALT. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN BALT. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2814 Waterview Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JULIUS CARROLL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSIE Phillips | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR IF YES, GIVE WAR OR DATES) yes | | | |
| 16b. SOCIAL SECURITY NO. 438-14-4140 | | 17. INFORMANT ADDRESS James L. Carroll 2814 Waterview | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RESPIRATORY INSUFFICIENCY 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ① MALNUTRITION ② ATELECTASIS ③ RIGHT LUNG ④ POST RESECTION CARCINOMA RIGHT LUNG | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17, 19 82, to 7/4, 19 82, that (I) (we) lost saw the deceased alive on 7/3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE LOPE T. ULLA JR. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOPE T. ULLA JR. | | | | 22e. ADDRESS 7600 OSLER DRIVE TOWSON | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 6 1982 James J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 3 8

REG. NO.

| | | | | | | |
|--|--|--|--|--|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARIAN MIDDLE CARROLL LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/31/82 | | 2b. HOUR 12:35 M | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10 03 03 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. CITIZEN OF WHAT COUNTRY? US | | 8. BALTIMORE CITY OR COUNTY OF DEATH city | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE SQUARE N.H. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STREET ADDRESS 7352 Furnace Branch Road | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT SHORT | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCINDA HAWKINS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A | | 16b. SOCIAL SECURITY NO. 213-14-017 | | 17. INFORMANT James H. Short Box 636 LaPlata Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 10-21 1981 to 7-31 1982, that (I) (we) last saw the deceased alive on 7-5 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) not view the body after death. | | 22b. SIGNATURE L. Reidner | | |
| 22c. DATE SIGNED 7-31-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER M.D. | | 22e. ADDRESS 1406 Crain Highway Suite 102 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8-5-82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery Baltimore | | |
| 23d. LOCATION CITY OR TOWN COUNTY Baltimore Baltimore Md. | | 24. FUNERAL DIRECTOR NAME Wm. M. March F/H 1101 E. North Avenue | | 25a. DATE REC'D. BY REGISTRAR AUG-3 1982 | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 3 9
REG. NO.

| | | | | | | |
|--|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur L. Carter Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR July 14, 1982 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 20 19 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 62 | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2312 Braddish Avenue | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2312 Braddish Avenue | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Arthur L. Carter Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Crawley | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-18-0630 | | 17. INFORMANT ADDRESS Pauline B. Carter 2312 Braddish Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased on July 14, 1982 , 19____, to July 1982 , 19____, that (I) (we) lost saw the deceased alive on _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE SWEINER | | DEGREE | | 22c. DATE SIGNED 7/16/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SWEINER | | 22e. ADDRESS 1900 E. Arthur P. Dr. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | |

NOV 10 2010



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | 7 2 1 7 4 4 0 REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Catherine Carter | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 4 5 82 | | | 2b. HOUR 230 P.M. | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 4 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | | | 13b. COUNTY --- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob E Summers | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST XXXXX Laura Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No XXXXX | | | | | 16b. SOCIAL SECURITY NO. 220-24-2898 | | 17. INFORMANT ADDRESS Apt. 103 20853 Mrs. May King 12514 Viers Mill Rd. Rockville MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest 2° ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Acute abdomen, etiology unknown DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 days | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). Atrial fibrillation, diabetes mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 4, 1982, to July 5, 1982, that (I) (we) lost saw the deceased alive on July 5, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Donald M. Lai</i> | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 7/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald M. Lai | | | | | | 22e. ADDRESS 301 St. Paul Place - Balto, Md 21202 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE July 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Maryland | | | |
| 24. FUNERAL DIRECTOR Smith, Keeney and Basford 106 East Church St. Frederick, MD. 21701 | | | | | | 25. DATE REC'D. BY REGISTRAR JUL 12 1982 | | | | |

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2021-0-0100

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examination must be utilized as indicated.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--------------------------|--|---|--|--------------------------|---|---------------------|-----------------------------------|--|----------|--|
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 | | 1 7 4 4 1 | | | |
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | MONTH DAY YEAR | | 2b. HOUR | | | |
| TUESDAY L. CASEY | | | | | July 15, 1982 | | | | | 7:55pm | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | |
| Female | | White | | Nov. 12 1980 | | | 1 | | MONTHS DAYS | | HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Md. | | U.S.A. | | | | | BALTIMORE CITY | | | | | MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | THE JOHNS HOPKINS HOSPITAL | | | | | | | | None | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | |
| Md. | | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6141 | | McBeth Dr. | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Jeffrey J. CASEY | | | | | Edith D. Robertson | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | ADDRESS | | | |
| No | | | | | None | | Jeffrey J. Casey | | | | | Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>7452</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LOW CARDIAC OUTPUT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 HRS</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u> | | | | | |
| PART 2. OTHER TERMINAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>CONGENITAL HEART DISEASE, SIF REPAIR, TETANUS FALLOUT</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 7-14-82 | | | | TETANUS FALLOUT | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-13-82</u> to <u>7-15-82</u> that (I) (we) last saw the deceased alive on <u>7-15-82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE <u>Michael Borkun MD</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-15-82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. MICHAEL BORKUN MD</u> | | | | 22e. ADDRESS <u>Johns Hopkins Hospital</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | 23b. DATE <u>7-20-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>Henry W. Jenkins & Sons Co., Balto., Md.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 19 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Van Thien</u> | | | | | | | | | |

HARRY W. JENNINGS & SON, CO., BALTIMORE, MD.
1892 YORK ST.

Handwritten notes and signatures, including "J. W. Jennings" and "J. W. Jennings & Son, Co." in various orientations.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8 2 1 7 4 4 2 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY CASKEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 5, 1982 | | | 2b. HOUR 11:10 M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edgewood Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier | | 12b. KIND OF BUSINESS OR INDUSTRY Hotel | |
| 13a. STATE Maryland | | 13b. COUNTY Balt | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6603 Ellsmere Place | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles L. Doudiken | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Brandt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 212 07 3788 | | 17. INFORMANT ADDRESS Mrs. Joseph McGlone, Balto., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2030 IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-17 , 19 80 , to July 5 , 19 82 , that (I) (we) last saw the deceased alive on June 27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Manuel Sodaro | | | | | DEGREE M.D. | | 22c. DATE SIGNED July 6 - 82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Manuel Sodaro, M.D. | | | | | 22e. ADDRESS 826 E. Belvedere Ave., Balto., Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natten | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 4 4 3 REG. NO. | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel S Cassidy | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 18 82 | | 2b. HOUR 1:38 P.M. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 8 14 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 69 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 1 YEAR HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Seed Samaritan | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY 0 | | 13c. CITY OR TOWN Balto. City | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2229 E. Pratt St. 21231 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Garfield Cassidy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Chapman | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 237074663 | | 17. INFORMANT ADDRESS PO Box 2167 A. Columbia 21040 Mrs. Greta McCoy - dght 43228 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Necrotic Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Obstructive Pulmonary Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) _____ the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Hawb Aoun | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 7/18/82 13 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hawb Aoun | | 22e. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 7/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE James J. VanHatten | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | 8 2 1 7 4 4 4 REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) RALPH B. CATLETT | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/25/82 | | | | 2b. HOUR 4:08 P | | |
| 3. SEX M | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 4 30 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7b. BIRTHPLACE COUNTRY W. Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Diabetic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE md | | | | | 13b. CITY OR TOWN Baltimore | | 13c. STREET ADDRESS 2001 W. W. KENS AVE. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James E. Cathett | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Fields | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown | | | 16b. SOCIAL SECURITY NO. 233-249322 | | 17. INFORMANT Chart. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4479 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) adult respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF (c) cardiac arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) septicemia, renal failure | | | | | | | | | |
| 19a. DATE OF OPERATION 7-16-1982 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aorta-Thro disease | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/24/82 19 to 7/25/82 19, that (I) (we) last saw the deceased alive on 7/25/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) (do not) know the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joan Higley, Jr. M.D. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | DATE SIGNED 7/25/82 | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. M. APOLITO | | | 22d. ADDRESS 2000 W. BALTIMORE ST | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE July 28 '82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah | | 23d. LOCATION CITY OR TOWN COUNTY STATE Preston Co. W. Virginia | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler, Inc. 1901 Eastern Ave. Balto. Md. | | | 25a. DATE RECEIVED BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 4 4 5 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST VERNON E. CAVEY | | | | MONTH DAY YEAR July 8 1982 | | | |
| 3. SEX MALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 9/16/09 | | 2b. HOUR 1:50 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | |
| 13a. STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? ? ? | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 212-18-5261 | |
| 17. INFORMANT ADDRESS JMA CAVEY (SAME) | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4310 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (this hospital) attended the deceased from 7/5 1982, to 7/8 1982, that (we) last saw the deceased alive on 7/8/82 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Mark R Stronbers MD | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT) Mark R Stronbers | | 22d. ADDRESS 3617 Charleston | | 22e. DATE SIGNED 7/8/82 | | 22f. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO, CO, MD | |
| 24. FUNERAL DIRECTOR NAME Paul E. Donovan | | 24b. ADDRESS 3617 Charleston | | 24c. DATE RECEIVED BY REGISTRAR JUL 16 1982 | | 24d. REGISTRAR'S SIGNATURE Frances Jean Nathan | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 13a-e per phone 7/26/82 dad STATE OF MARYLAND

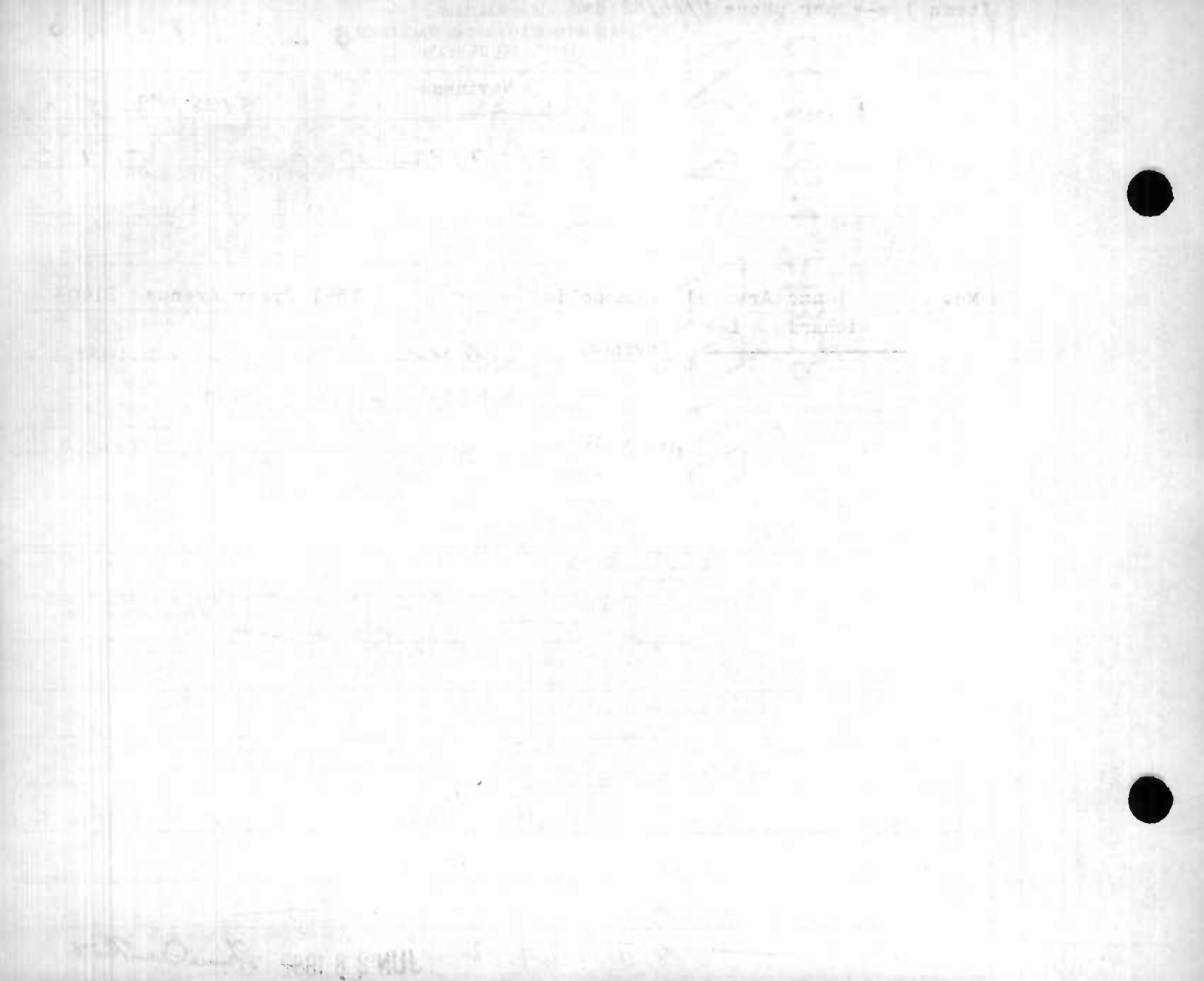
FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 4 4 6

| | | | | | | | | |
|---|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Baby Boy | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/28/82 | | | 2b. HOUR 3:06 a M | | |
| 3. SEX m | | | 4. RACE B | | | 5. DATE OF BIRTH MONTH DAY YEAR 5/27/82 | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | | 7a. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Balt | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BCH | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD. | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD-us | | | 13b. COUNTY Anne Arundel | | | 13c. CITY OR TOWN Annapolis | | |
| 14. FATHER'S NAME FIRST Richard MIDDLE Lee LAST Caviness | | | 15. MOTHER'S MAIDEN NAME FIRST Wanda MIDDLE Dawnes | | | 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 2 | | | 17b. SOCIAL SECURITY NO. — | | | 17. INFORMANT ADDRESS m Behar md BCH | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: 7651 IMMEDIATE CAUSE (a) prematurity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) — | | | | | | | | |
| 19a. DATE OF OPERATION — | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 5/27 , 19 82 , to 3/28 , 19 82 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE m Behar DEGREE md | | | | | | 22c. DATE SIGNED 5/28/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) m Behar md | | | | | | 22e. ADDRESS BCH | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) removal | | | 23b. DATE 5/28 | | | 23c. NAME OF CEMETERY OR CREMATORY — | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | | 23e. DATE REC'D. BY REGISTRAR JUN 28 1982 | | | 23f. REGISTRAR'S SIGNATURE James J. Smith | | |
| 24. FUNERAL DIRECTOR NAME Balt City Hosp | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 4 4 7 | | | | |
|--|--|--|--|---|---|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 29 82 | | | | | | | 2b. HOUR 11:05 AM | | |
| 3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE CEO | | | | | 4. SEX MALE | | | | | | | 5. RACE BLACK | | |
| 6. DATE OF BIRTH MONTH DAY YEAR 5 14 1886 | | | | | 7. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | | | | | | | 8. IF UNDER 1 YEAR MONTHS DAYS 2 15 | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | | | | 10. CITIZEN OF WHAT COUNTRY? USA. | | | | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | | | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. Gen. Hosp. | | | | | 14. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City. MD. | | | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | | | 16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 17. STREET ADDRESS 215 Warfield. | | | | |
| 18. FATHER'S NAME FIRST MIDDLE LAST (KANE) Cain CEO | | | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE | | | | | 20. SOCIAL SECURITY NO. 250-30-6207 | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 22. INFORMANT DAUGHTER. | | | | | 23. ADDRESS | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Art. Scr. Cor. Art. Disease | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 25a. DATE OF OPERATION | | | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 28c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 29a. I certify that (I) (this hospital) attended the deceased from July 29, 19 82, to July 29, 19 82, that (I) (we) lost saw the deceased alive on May 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death on the clinic. | | | | | | | | | | | | | | |
| 29b. SIGNATURE Gerard M. Lowder | | | | 29c. DATE SIGNED 7/29/82 | | | | 29d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD M. LOWDER. | | | | 29e. ADDRESS 3001 S. HANOVER STREET | | |
| 30a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 30b. DATE 8/1/82 | | | | 30c. NAME OF CEMETERY OR CREMATORY Smith Cemetery | | | | 30d. LOCATION CITY OR TOWN COUNTY STATE Mullins, S. C. | | |
| 31. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | 31. DATE REC'D. BY REGISTRAR 30 80 1982 | | | | 31. REGISTRAR'S SIGNATURE | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 4 8

REG. NO.

| | | | | | | | | | | | |
|---|--|------------------------|---|---|--|--|--|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) Theodore J Chainey | | | 2a DATE OF DEATH MONTH 7 DAY 31 YEAR 82 | | | 2b HOUR 5 P M | | | | | |
| 3 SEX Male | | 4 RACE Black | | 5 DATE OF BIRTH MONTH 02 DAY 22 YEAR 22 | | 6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS | | 7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 8 IF UNDER 24 HRS HOURS 0 MIN. 0 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Balt. Md. MD. | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept of Ed. | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Baltimore City 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET ADDRESS 6824 McClean Blvd. | | | 21238 | | |
| 14 FATHER'S NAME FIRST Thomas MIDDLE J. LAST Chaney | | | 15 MOTHER'S MAIDEN NAME FIRST Heleen MIDDLE Jackson LAST Jackson | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) | | | 16b SOCIAL SECURITY NO. 218-18-8409 | | | 17 INFORMANT Nancy Woodhouse | | | ADDRESS 1914 E. 29th Balt. | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemophysis - uncontrolled. 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Lung unresectable Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. @ main bronchus DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION Cryosurgery | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction of @ Bronchus | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) this hospital attended the deceased from 7-15-82 , 19 82 , to 7-31 , 19 82 , that (I) we last saw the deceased alive on 7-31 , 19 82 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE Claudio Levin | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED 7-31-82 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) Claudio Levin | | | 22e ADDRESS Sinai Hospital | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b DATE 8-5-82 | | | 23c NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery | | | 23d LOCATION CITY OR TOWN Crownsville, COUNTY Md. STATE Md. | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue ADDRESS | | | | | | 25a DATE REC'D. BY REGISTRAR AUG-3 1982 | | | 25b REGISTRAR'S SIGNATURE Frances Jean Nathan | | |

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and includes various words and phrases, some of which are partially legible. The handwriting is cursive and appears to be from the late 19th or early 20th century. The text is organized into several lines, with some words appearing in larger, more prominent script than others. The overall appearance is that of a document page with significant ink transfer from the back.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|---|------------------------------------|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie B. CHAMBERS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 30, 1982 | | 2b. HOUR 5:50a M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 5 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 919 Whitelock Street | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Chambers | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Purdy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-20-8931 | | 17. INFORMANT Mary Jones | | ADDRESS 2415 Eutaw Place | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and chronic Pancreatitis DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic fatty metamorphosis DUE TO, OR AS A CONSEQUENCE OF (c) Clinical hepato-renal sundrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Arteriosclerotic cardiovascular disease. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that xx (this hospital) attended the deceased from July 21 , 19 82 , to July 30 , 19 82 , that xx (we) lost saw the deceased alive on July 30 , 19 82 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above xx (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Edmond McDonnell, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 7/30/82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | |
| 25b. REGISTRAR'S SIGNATURE Francis Van Natta | | | | | | | | | |

CHARTERS

1171

July 20, 1952

California

Armed Forces Hospital

San Francisco

Acute myocardial infarction

Chronic coronary atherosclerosis

Left ventricular hypertrophy

Coronary artery disease

July 20, 1952

1171

xx

Armed Forces Hospital

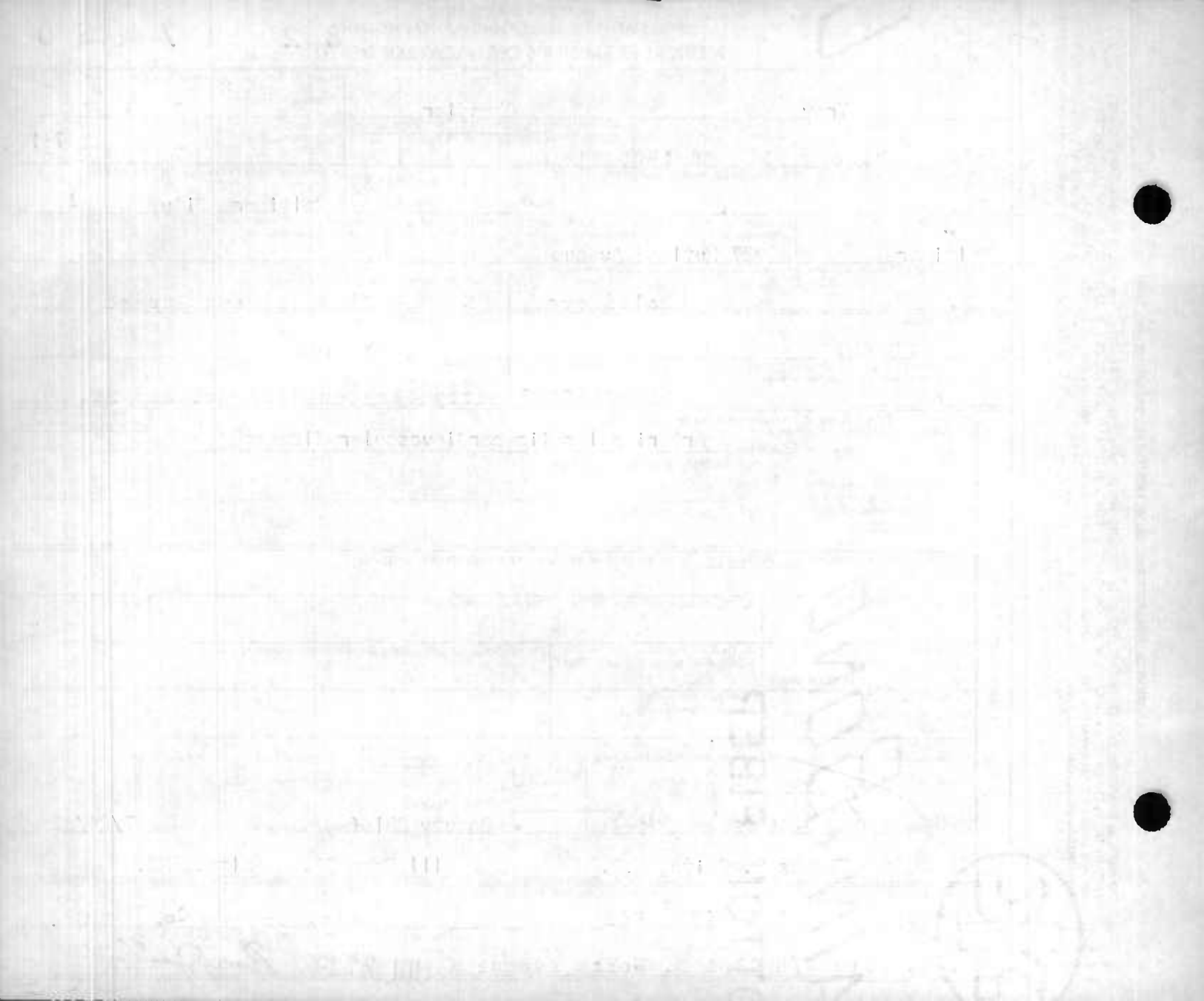
San Francisco

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17450 | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Troy Chandler | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7 23 19 82 | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 28 1900 | | 6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 7 23 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 927 Rutland Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2123 Orleans Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 219-32-2297 | | 17. INFORMANT ADDRESS Betty Clayton 2123 Orleans St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 7/24/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY King | | 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY Co. | | STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |
| ADDRESS F/H 1101 E. North Avenue | | | | | | | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|---|--|------------------|--|---|---|---|--|--|---|---|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Linnea Charles | | | | | | 2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 7 30 19 82 | | | 2b. HOUR M 12:15 | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 10 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 3mo 9d | | 7c. DATE PRONOUNCED DEAD 7 30 19 82 | | 7d. HOUR M 8. M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 2133 E. Oliver Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Davis | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No. | | | 16b. SOCIAL SECURITY NO. N/A | | | 17. INFORMANT ADDRESS Shirley Davis 2133 E. Oliver St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-30-82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8-5-82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG-4 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | | |

Blank lined paper with two punch holes on the right side.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 4 5 2
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|---|---|---|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Oliver Chase | | | 2a. DATE OF DEATH MONTH DAY YEAR July 28, 1982 | | 2b. HOUR 2:50 a.m. | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 15 08 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 8. CITIZEN OF WHAT COUNTRY? USA. | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS 3607 W. Mulberry Street | | |
| 13b. COUNTY Maryland | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joe Chase | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kizzie | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 214-14-0177 | | 17. INFORMANT ADDRESS Swindell B. Chase 3607 W. Mulberry St. | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Metastatic Adeno Carcinoma of Prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that XX (this hospital) attended the deceased from July 20 , 19 82 , to July 28 , 19 82 , that X (we) lost above (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Krishna Prasad | | DEGREE MD | | 22c. DATE SIGNED 7-28-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Krishna Prasad, M.D. | | 22e. ADDRESS C/O Maryland General Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | |
| 25. DATE RECEIVED BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE John H. H. H. | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

QCM

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS. IF THE DECEASED WAS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|---|--|------------------------|---|--------------------|-------------------------------------|--|-----------|------------------------|---|----------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE KNOWN OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE KNOWN OF DEATH | | 3. MONTH | |
| Diggs | | Chauncey | | | | | | 7. 8 | | 19 82 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 10. MONTH | 11. DAY | 12. YEAR | 13. HOUR | 14. MIN. |
| Male | Black | 7 8 82 | 57 yrs. | | | 7 8 19 82 | | | | 10:16 | |
| 15. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 16. CITIZEN OF WHAT COUNTRY? | 17. MARRIED | 18. NEVER MARRIED | 19. WIDOWED | 20. DIVORCED | 21. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| North Car. | USA | | | | | Baltimore City | | | | | |
| 22. CITY OR TOWN OF DEATH | 23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 24. USUAL OCCUPATION (TYPE OF WORK) | | | | 25. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | Sinai Hospital | | | | Laborer | | | | | | |
| 26. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 27. STATE | 28. COUNTY | 29. CITY OR TOWN | 30. INSIDE CITY LIMITS? | 31. STREET ADDRESS | | | | | | | |
| Md. | | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2418 Oswego Ave. | | | | | | | |
| 32. FATHER'S NAME | | | 33. MOTHER'S MAIDEN NAME | | | | | | | | |
| Lester Diggs | | | Clara | | | | | | | | |
| 34. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 35. SOCIAL SECURITY NO. | | | 36. INFORMANT ADDRESS | | | | | |
| yes | | | 245 28 2863 | | | Christine Diggs 2418 Oswego Ave | | | | | |
| 37. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 4292 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 38. DATE OF OPERATION | | | 39. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 40. AUTOPSY? | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 41. EXTERNAL CAUSE WAS | | | 42. TIME OF INJURY | | | 43. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 44. INJURY OCCURRED | | | 45. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 46. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 47. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| 48. ACTUAL SIGNATURE | | | | | | 49. TITLE (SPECIFY) | | | 50. DATE SIGNED | | |
| H. R. Guard | | | | | | M.D. Assistant | | | 7/9/82 | | |
| 51. EXAMINER'S NAME (TYPE OR PRINT) | | | | | | 52. ADDRESS | | | 53. DATE REC'D. BY REGISTRAR | | |
| Hormez R. Guard, M.D. | | | | | | 111 Penn Street, Balto. MD 21201 | | | JUL 12 1982 | | |
| 54. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 55. DATE | | | 56. NAME OF CEMETERY OR CREMATORY | | | 57. LOCATION | | |
| Burial | | | 7/12/82 | | | Crownsville Vet. Cem | | | CROWNSSVILLE, MD | | |
| 58. FUNERAL DIRECTOR | | | | | | 59. DATE REC'D. BY REGISTRAR | | | 60. REGISTRAR'S SIGNATURE | | |
| LEROY O. DYETT 4600 LIBERTY HGTS. AVE. | | | | | | | | | James J. Smith | | |



RELEASED BY MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 7 2 1 7 4 5 4 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| IDA CHILDRESS | | | | | 7 15 82 P.M. | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | CAUCASIAN | | 8 MONTH DAY YEAR 8 9 25 | | 56 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. Married Divorced Widowed Separated | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore, Md. | | U.S.A. | | | | Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Baltimore City Hospitals | | | | Housework | | At Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | |
| 13a. STATE COUNTY Maryland | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. 1315 Bursen Way 21224 | | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| 14a. FIRST MIDDLE LAST William H. Evans | | | | | 15a. FIRST MIDDLE LAST Emma V. Heck | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES | | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | |
| No | | | | | 213-20-7454 | | Gloria Blatcher 1315 Drew Street 21224 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest | | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) severe atherosclerotic cardiovascular disease years | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | | | |
| 22a. I certify that (he/she) attended the deceased from October 19 80, to July 15, 19 82, that (he/she) lost | | | | | | | | | |
| saw the deceased alive on 7-15 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| R. Boutwell | | | | | MD | | | 7-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| R. BOUTWELL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 7-19-82 | | Oak Lawn Cemetery | | Eastwood, Balto. Co., Md. | | |
| 24 FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| C.S. Zeiler & Son Inc. 6224 Eastern Avenue | | | | | JUL 19 1982 Charles J. and Andrew | | | | |

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1 - STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 7 4 5 5 | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NATHALIA ANN CHRISTY | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 29 82 | | 2b. HOUR 1130 P.M. |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 24 1956 | | 6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY None |
| 13a. STATE Maryland | | 13b. CITY OR TOWN Harford | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 467 Washington Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Vernon Benson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Christy | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-66-6228 | | 17. INFORMANT ADDRESS Maryland 21001 Geraldine Christy, 467 Washington St., Aberdeen | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4019 Refractory Hypotension DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 29 82 to July 29 82 , that (I) (we) lost saw the deceased alive on July 29 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Vikas Saini | | DEGREE MD | | 22c. DATE SIGNED 7-30-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vikas Saini | | 22e. ADDRESS 4940 Easter Ave Balt md 21224 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2 August 82 | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, R.D., Harford Md. |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3392 | | | 25a. DATE REC'D. BY REGISTRAR AUG 5 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE John J. Conner | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADAM CISZEK | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-23-82 | | 2b. HOUR 12:45 P | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12-20-93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY H.A. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5422 WASENA AVE. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE CISZEK | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MANNOL | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 217-12-0307 | | 17. INFORMANT ADDRESS MOLLIE IGNATOWSKI 1402 GITTINGS AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5272 IMMEDIATE CAUSE (a) SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PAROTITIS, RIGHT (c) PAROTITIS, RIGHT | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: RENAL FAILURE, ACUTE; PNEUMONIA | | | | | | | | | |
| 19a. DATE OF OPERATION 7-20-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MUCUS PLUGGING, RLL | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 07-13-82 , 19 82 , to 07-23-82 , 19 82 , that (I) (we) last saw the deceased alive on 07-23-82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cesar Gamboa, M.D. | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-23-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CESAR GAMBOA, M.D. | | | | 22e. ADDRESS 40 N. CHARLES GENERAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE DUNDALK BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME | | | | ADDRESS 6500 YORK RD. | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | |

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Female White June 1, 1911 21

Superior, U.S.

County

1000 White female

Florence, Illinois

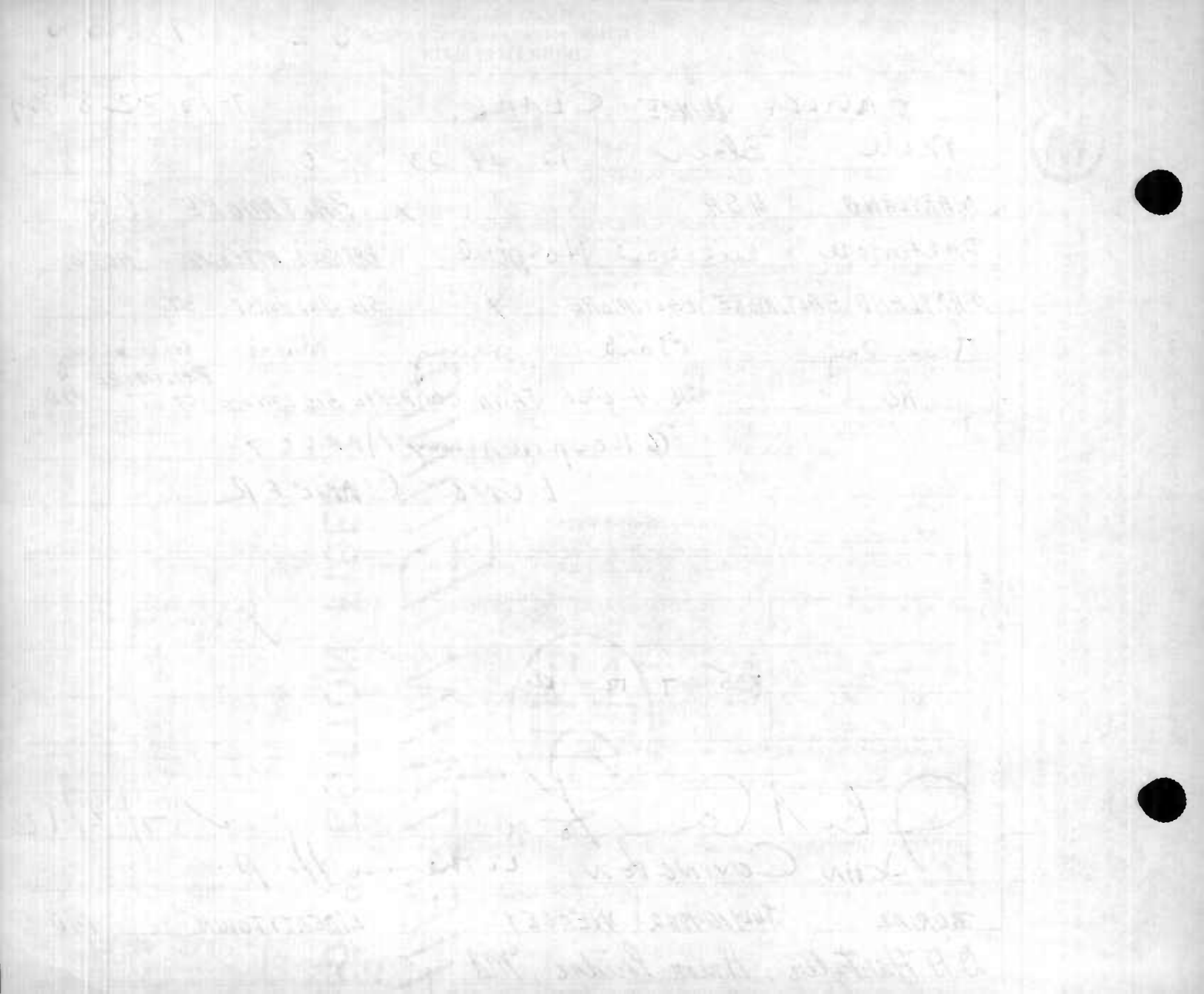
State of Illinois

1217 00 0000 1217 00 0000 1217 00 0000

United States Department of Agriculture

June 1, 1911

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|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ORVILLE QUINCE CLARK. | | 2a. DATE OF DEATH 7-12-82 | | 2b. HOUR 8:50 PM | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 12 DAY 24 YEAR 23 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST Jesse Ray MIDDLE Clark LAST Clark | | 15. MOTHER'S MAIDEN NAME FIRST Maury MIDDLE Maury LAST millberry | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PARKING ATTENDANT | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-14-6766 | | 17. INFORMANT FAWN CORPORAL, 515 LYN DHURST ST MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) @ Respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 805 P.M. 7 12 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated 22b. SIGNATURE John A. Covington DEGREE _____ 22c. DATE SIGNED 7/12/12 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN COVINGTON | | 22e. ADDRESS Lutheran Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 16-1982 | | 23c. NAME OF CEMETERY OR CREMATORY WESLEY | |
| 24. FUNERAL DIRECTOR NAME D D Hartzler ADDRESS Union Bridge, Md | | 25a. DATE REC'D. BY REGISTRAR 7/15/82 25b. REGISTRAR'S SIGNATURE Zane Santer | | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) GUSSIE | | FIRST CLARKSON | | MIDDLE CLARKSON | | LAST CLARKSON | | 2a. DATE OF DEATH MONTH DAY YEAR 7-28-82 | | 2b. HOUR 5:25 AM | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7-19-26 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 yrs | | IF UNDER 1 YEAR MONTHS DAYS 56 | | IF UNDER 24 HRS. HOURS MIN. 56 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FEDERAL HILL NURSING CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1213 Light St. 21230 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES CLARKSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-9652 | | 17. INFORMANT ADDRESS | | | | | | | |

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| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
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| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10 Carcinoma Stomach, Dental Retardation, gastrointestinal bleeding, Scurvy. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21e. LOCATION STREET CITY OR TOWN COUNTY STATE | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE Michael R. Reed MD | | DEGREE | |
| 22c. DATE SIGNED 7/29/82 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BOB A | | 23b. DATE 8/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY ARROW CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROCK HALL KENT MD | |
| 24. FUNERAL DIRECTOR WALTER FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. VanNathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. 8 2 1 7 4 6 0 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS L. CLAYTOR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 20 82 | | 2b. HOUR 5p M | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 05 18 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY BETHLEHEM | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTO. HGLDS. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS STEEL 3901 ANNAPOLIS ROAD, 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS CLAYTOR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BUTZ | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-8730 | | 17. INFORMANT ADDRESS MARY CLAYTOR 3901 ANNAPOLIS ROAD, 21227 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe chronic Obstructive Lung Disease years DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7/20 19 80 to 7/20 19 82, that (1) I/we last saw the deceased alive on 7/20 19 82, and that in my/our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE Maura Dollymore MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/20/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maura Dollymore MD | | | | | 22e. ADDRESS University Hosp. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | |

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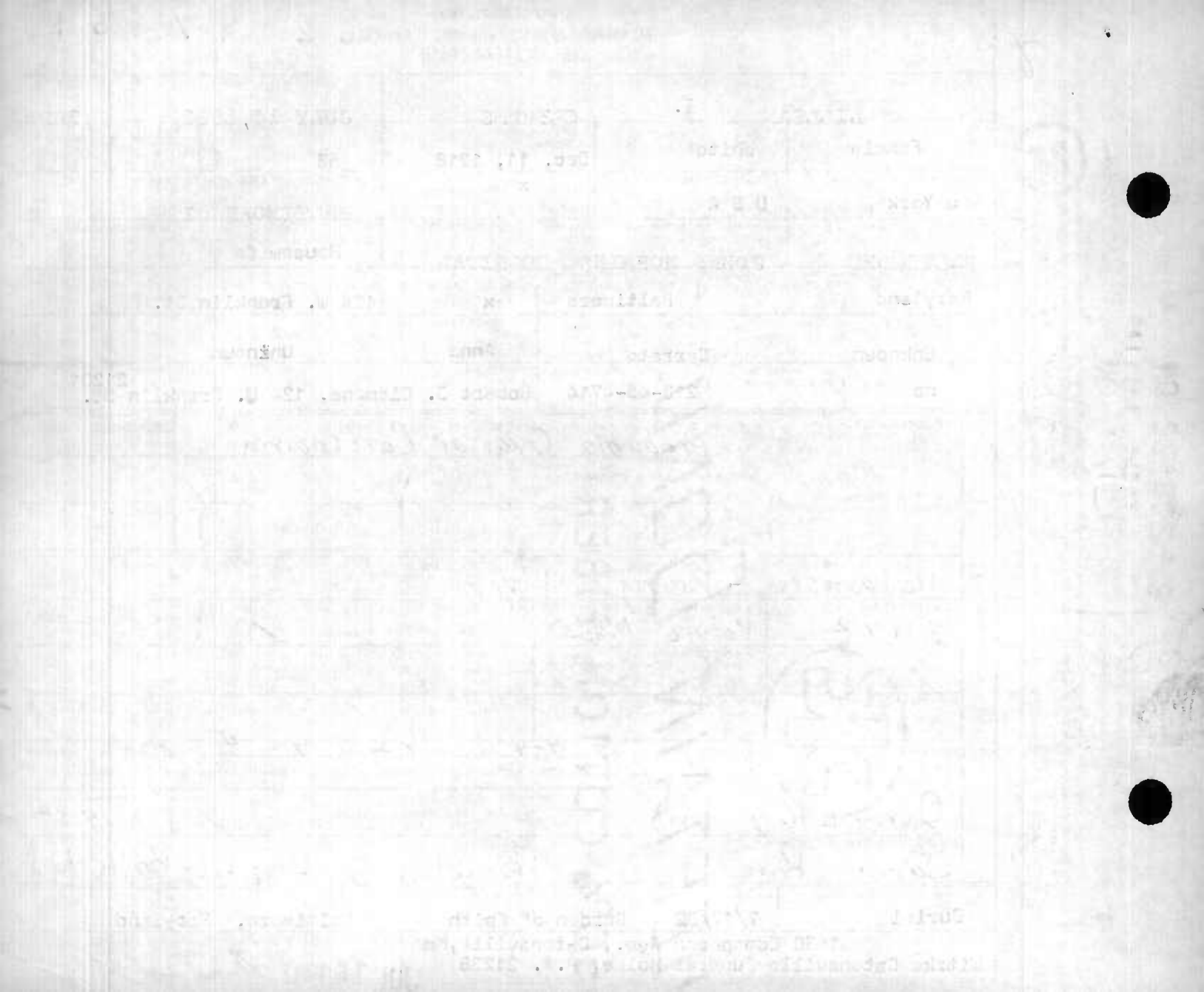
LILLIAN CLEMENS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 4 6 1 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN I. CLEMENS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1982 | | 2b. HOUR 1:36 P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 1:36 P M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 124 W. Franklin St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown Cerrato | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 213-46-4714 | | 17. INFORMANT ADDRESS Robert J. Clemens, 124 W. Franklin St. 21201 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Ovarian Carcinoma 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Metastasis to lung + liver | | | | | | | | | | | |
| 19a. DATE OF OPERATION 3-19-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pelvic Mass | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-4 , 19 82 , to 7-14 , 19 82 , that (I) (we) last saw the deceased alive on 7-14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Janet L Rice md | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-14-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Janet Rice | | | | 22e. ADDRESS Franklin St. Hospital, Balto. Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Garden of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave., Catonsville, Md Witzke Catonsville Funeral Home, P.A. 21228 | | | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE JUL 16 1982 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN ARTHUR CLEMONS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 31 82 | | | | | | |
| 3. SEX Male | | | | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 3 15 | | 2b. HOUR 8:40P M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veteran Hospital | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 401 E. 25th Street Apt. 2n | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Clemons | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Liza | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 218-03-8142 | | 17. INFORMANT ADDRESS Jessie B. Cooke 1425 N. Milton Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SQUAMOUS CELL CARCINOMA OF LUNG</u> (c) <u>OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 3900 LOCH RAVEN BLVD. BALTO. MD. 21218 | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from <u>6-30</u> , 19 <u>82</u> , to <u>7-31</u> , 19 <u>82</u> , that we (we) lost saw the deceased alive on <u>7-31</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (view) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Carla S. Alexander, MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLA S. ALEXANDER, MD | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | | 23d. LOCATION CITY OR TOWN Crownville, | | COUNTY STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | | 25a. DATE REC'D. BY REGISTRAR AUG -4 1982 | | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |

MEMORANDUM FOR THE CHIEF OF STAFF
SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 4 6 3 | |
|---|--|--|--|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HILDA ANNA CLOPETN | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-17-82 | | | 2b. HOUR 6⁵⁵ A.M. | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt. city MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CANDY MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY CANDY COMPANY | | | |
| 13a. STATE MD | | 13b. COUNTY --- | | 13c. CITY OR TOWN Balto | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1610 FOREST HILL AVENUE, 21230 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles - Scheller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE - HOENES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-7276 | | 17. INFORMANT ADDRESS PAMELA A. DeMONTAIGNE 6 KENWOOD AVENUE 21228 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) cardio-pulmonary arrest 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Intestinal Obstruction | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from July 11, 1982 , to July 17, 1982 , that (1) (we) last saw the deceased alive on July 17, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (we) did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Anna Barnett | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-17-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANNA BARNETT | | | | | | 22e. ADDRESS 3001 S. Hanover St., Balto Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 07-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | | | ADDRESS 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | |

CP

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4

1- FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 4 6 4

1. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) HERMAN L COFFEY

2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1982

2b. HOUR 10:15 AM

3. SEX m

4. RACE W

5. DATE OF BIRTH MONTH DAY YEAR 12 8 1922

6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.

7b. CITIZEN OF WHAT COUNTRY? USA.

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.

10. CITY OR TOWN OF DEATH BALTO

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HILTON HOTEL

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE MD

13b. COUNTY BALTO

13c. CITY OR TOWN DUNDALK

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS 2012 WAREHAM RD.

14. FATHER'S NAME FIRST MIDDLE LAST SILAS M COFFEY

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET PHAUGH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES

16b. SOCIAL SECURITY NO. W W H 240-28-5794

17. INFORMANT ADDRESS TEKLA COFFEY SAME

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) ADVANCED SQUAMOUS CELL CARCINOMA RIGHT LUNG WITH METASTASIS
DUE TO, OR AS A CONSEQUENCE OF (b) RIGHT PNEUMONECTOMY
DUE TO, OR AS A CONSEQUENCE OF (c) TRACHEOSTOMY
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION JUNE 28, 1982; JULY 15, 1982

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER RIGHT LUNG

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) this hospital attended the deceased from JUNE 9, 1982, to JULY 18, 1982, that (I) (we) lost the deceased alive on JULY 18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Sompalli Prasad

22c. DATE SIGNED JULY 18, 1982

22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOMPALLI PRASAD, MD.

22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL

23b. DATE 7/21/82

23c. NAME OF CEMETERY OR CREMATORY OAK LAWN

23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.

24. FUNERAL DIRECTOR NAME CORNELLY F.H. ADDRESS 300 MACE AVE.

25a. DATE REC'D. BY REGISTRAR JUL 20 1982

25b. REGISTRAR'S SIGNATURE Frances Van Natten



RECEIVED



NOTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| Items 13a-e per phone 7/26/82 | | | | STATE OF MARYLAND | | | |
|--|--|---|--|--|--|---|--|
| 1- STATE dad REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | |
| CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 4 6 5 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ^{FIRST} Cohoe Baby Boy ^{MIDDLE} John M. ^{LAST} Cohoe III | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. 0 MONTHS 15 DAYS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY Caroline | | 13c. CITY OR TOWN Preston | |
| 14. FATHER'S NAME ^{FIRST} John ^{MIDDLE} M. ^{LAST} Cohoe, Jr. | | | | 15. MOTHER'S MAIDEN NAME ^{FIRST} Digna ^{MIDDLE} BANNING ^{LAST} Cohoe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Maryland 21655 John M. Cohoe, Jr., Rt. 2, Box 175, Preston, | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 7718 IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14, 1982, to July 14, 1982, that (I) (we) lost the deceased above on July 14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Richard D. Cylus</i> DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk D. Cylus MD | | | | 22e. ADDRESS Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery | | 23d. LOCATION CITY OR TOWN County State Preston, Caroline, Maryland | |
| 24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St. | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE JUL 19 1982 | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|--|------------------------|---|----|---|----|------------------------|------|--|------|------------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8 2 1 7 4 6 6 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| AMELIA (MOLLY) R. CUMEN | | | JULY | | 24 | | 82 | | 3.34 | | P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| FEMALE | | WHITE | | JAN. 7, 1895 | | 87 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | USA | | | | BALTIMORE CITY | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BALTIMORE CITY | | NORTH CHARLES GEN. HOSP. | | HOUSEWIFE | | AT HOME | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2500 W. BELVEDERE AVE. | | 21215 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| SIMON | | RING | | MARY | | UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | |
| NO | | 213-32-6446 | | MR. HAROLD FREEMAN | | 6 POMONA SOUTH, APT. 7 | | BALTO., MD | | 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) 1539 CARDIORESPIRATORY FAILURE | | | | | | | | | | 15 mins | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF METASTATIC CARCINOMA OF COLON | | | | | | | | | | 5 months | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF LYMPHOMA | | | | | | | | | | 8 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | | |
| HYPERTENSION, ARTERIOCLEROTIC VASCULAR DIS., ASCITIS | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 6/28/82 | | CA COLON WITH METASTASIS TO LIVER | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| N/A | | HOUR A.M. MONTH DAY YEAR | | N/A | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> N/A | | N/A | | N/A | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/18/82 to 7/24/82, that (I) (we) lost saw the deceased alive on 7/24/82, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | | | |
| Chetaval Vutiganon | | M.D. | | | | 7/28/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| CHATEVAVAL VUTIGANON | | NORTH CHARLES GENERAL HOSPITAL | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| BURIAL | | JULY 26, 1982 | | BNAI ISRAEL | | BALTIMORE | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| SOL LEVINSON & BROS., INC. | | JUL 28 1982 | | Name of Registrar | | | | | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | | | | | |

Handwritten notes on lined paper, including a circular stamp and a large 'X' mark.

DHMH-16 30M 2/80
(VRA 15, 4)

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CCU 17 1 201 8 238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove earlier papers. Pages 1 and 2 should be filed by 1973 for the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 4 6 7

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
ELIZABETH Silver COLE

2a. DATE OF DEATH MONTH DAY YEAR
JULY 19 1982

2b. HOUR
7:04 AM

3. SEX
Female M

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
1-3-03

6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS.

IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE CITY MD.

10. CITY OR TOWN OF DEATH
BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
JOHNS HOPKINS HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland

13b. CITY
Baltimore

13c. CITY OR TOWN
Baltimore

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS
6110 Billinham Ct Apt 622

14. FATHER'S NAME FIRST MIDDLE LAST
Charles Bartol Silver

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Francina Christie Hopkins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
214-34-3276

17. INFORMANT ADDRESS
Mr. Charles W. Cole Jr. 8 Crestline Ct 21117

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4149 IMMEDIATE CAUSE (a) **Aortic Stenosis**
DUE TO, OR AS A CONSEQUENCE OF
(b) **pulmonary edema**
DUE TO, OR AS A CONSEQUENCE OF
(c) **cardiac ischemia**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **7/19**, 19 **82**, to **7/19**, 19 **82**, that (I) (we) lost saw the deceased alive on **7/19**, 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Chi V. Dang** DEGREE **M.D.** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED **7/19/82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **Chi V. Dang**

22e. ADDRESS **1620 McElderry Balt MD 21205**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation

23b. DATE
7-20-82

23c. NAME OF CEMETERY OR CREMATORY
Greenmount

23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore Maryland

24. FUNERAL DIRECTOR NAME
Mitchell-Wiedefeld Home ADDRESS
6500 York Rd 21212

25a. DATE REC'D BY REGISTRAR
JUL 23 1982

REGISTRAR SIGNATURE **James J. [Signature]**

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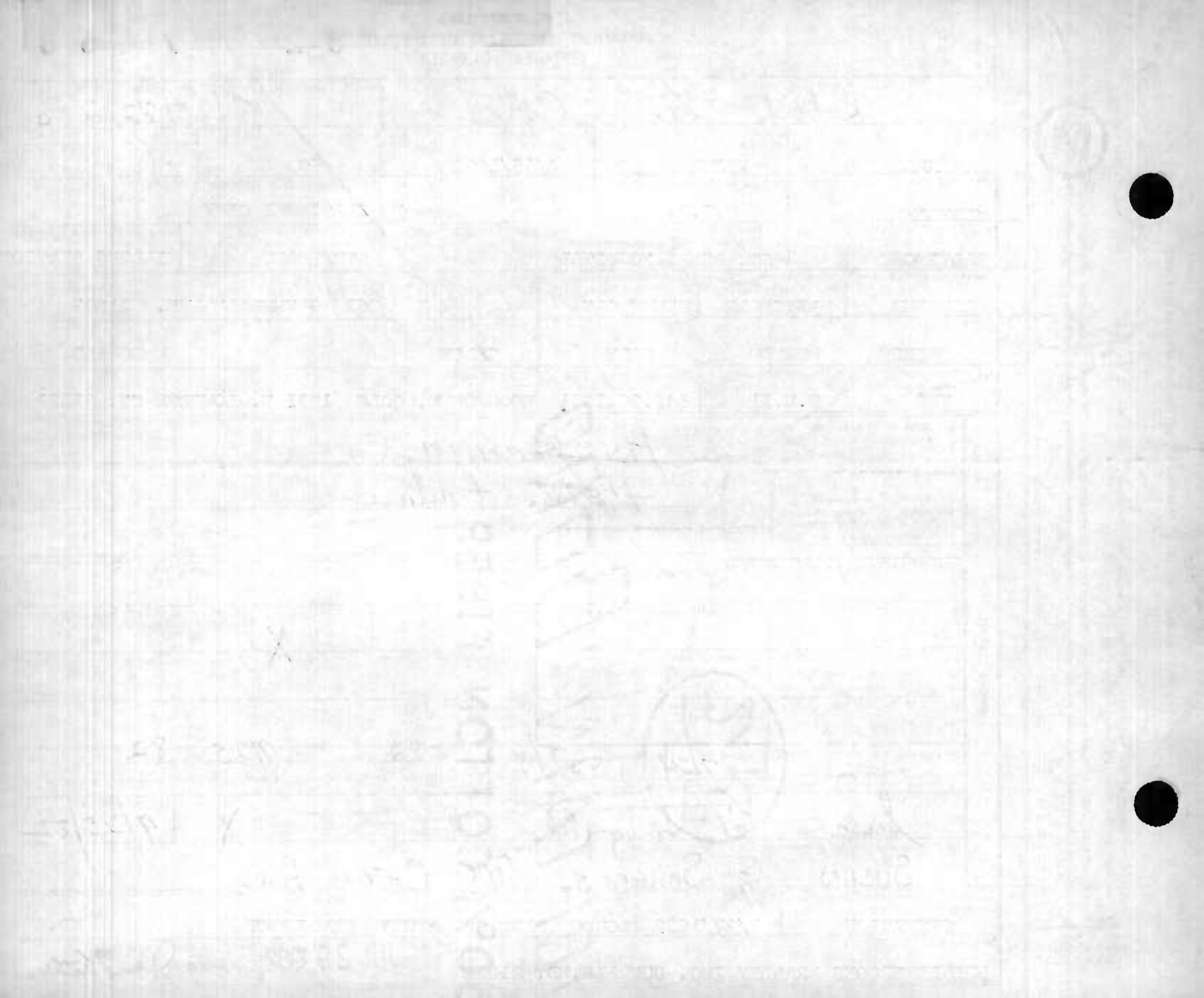
itcheil - isselela hove 6500 rok - id 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| FOR 1 - STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Robert Lee Cole</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7/25/82</i> 2b. HOUR <i>2:35</i> P.M. | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR <i>4/15/1922</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>60</i> | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTENDANT | | 12b. KIND OF BUSINESS OR INDUSTRY FILLING STATION | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN GYWNN OAK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT NEUTON COLE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE McDONALD | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES W.W.11 | | | | | 16b. SOCIAL SECURITY NO. 545.36.1251 | | 17. INFORMANT ADDRESS WOODROW W. COLE 1931 W. LOMBARD ST. 21223 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>5728</i> IMMEDIATE CAUSE (a) <i>Hypotension</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepatic failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> 19 <i>82</i> to <i>7/25</i> 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>7/24</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Susan G Smigocki</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>7/25/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN G SMIGOCKI | | 22e. ADDRESS 900 CATON Ave | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 7/27/1982 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD, | | | |
| 24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i> | | | |

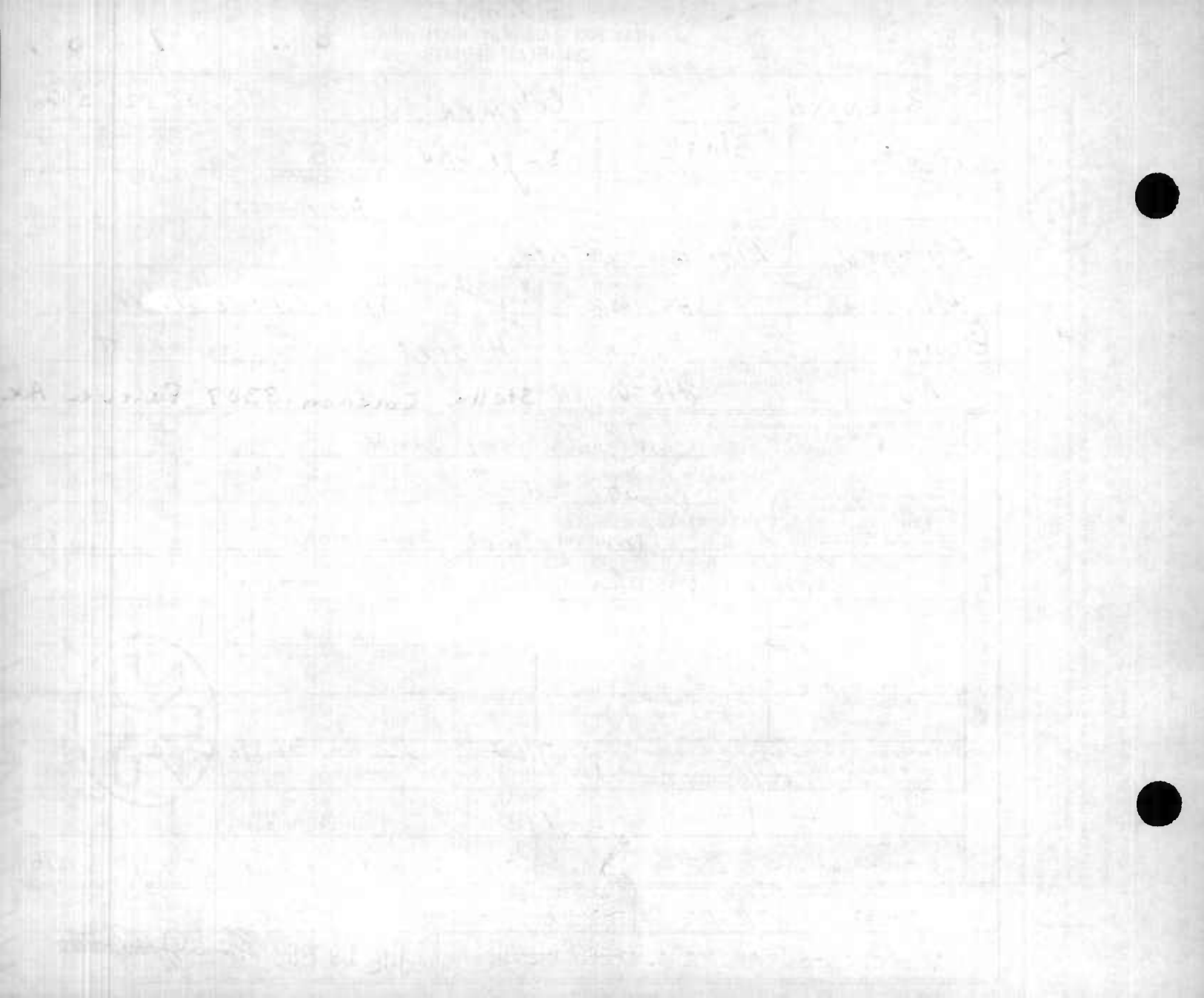


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 4 6 9 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernard Coleman | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-15-82 | | | |
| 3 SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 03-01-04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Coleman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Scott | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 218-05-1010 | | 17. INFORMANT ADDRESS Stella Coleman 3307 Fairview Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardropulmonary arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Peripheral Vascular Disease s/p Amputation | | | | | | | |
| 19a. DATE OF OPERATION July 3, 1982 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED POOR | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14/82, 19 82, to 7/15/82, 19 82, that (I) (we) last saw the deceased alive on 7/15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE CHENG CHUNG LZN | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHENG CHUNG LZN | | 22e. ADDRESS 730 Ashburton St. Baltimore K.D. 21216 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | 25c. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 4 7 0 REG. NO. | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAULINE D. COLES | | | | July 17, 1982 | | | | 6:20P _M | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Granada Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY 21215 | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3810 Dorchester Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Clark Davenport | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Bowman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT Eliza Brice | | ADDRESS 3810 Dorchester Rd. 21215 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NATURAL</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> (c) } DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1982</u> to <u>June 19, 1982</u> , that (I) (we) last saw the deceased alive on <u>June 15, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Mark Davis</u> DEGREE | | | | 22c. DATE SIGNED <u>7/18/82</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Davis, M.D. | | | | 22e. ADDRESS 9051 BMT MPT PILE E.C. MD 21243 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 21, '82 | | 23c. NAME OF CEMETERY OR CREMATORY Jefferson Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Alleghany County, PA | | | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | | | 24b. ADDRESS 8521 Loch Raven Blvd. | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE <u>Thomas J. ...</u> | |

20 COLT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called for an autopsy.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 4 7 1 REG. NO. | |
|---|--|---|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Paul Edward Cook | | | 2a. DATE OF DEATH MONTH DAY YEAR July 12, 1982 | | | 2b. HOUR 11:45 PM | | | | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. BALTIMORE GEN. HSP. | | | | 12a. USUAL OCCUPATION (Ret.) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD A.A. Co. Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 203 9th Avenue S.E. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOSIAH Emory Cook | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Priscilla Smith | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A | | 16b. SOCIAL SECURITY NO. 216-09-1406 | | 17. INFORMANT (Son) ADDRESS Mr. Jay E. Cook Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 DAYS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (this) hospital attended the deceased from 1 July 19 82, to 12 July 19 82, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. B. CORN | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 12 July 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. CORN | | | | 22e. ADDRESS 3001 S. HANOVER, BALTIMORE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 16 July 82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION Baltimore, COUNTY MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME G. Easter Singleton Funeral Home | | | | ADDRESS Glen Burnie, MD. | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE James Jan Nathan | | | |

MEDICAL CERTIFICATION

WAK

JUL 18 1955

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 7 2

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | |
|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Ruth</i> <i>Cook</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7 8 82</i> 2b. HOUR <i>8 12</i> AM | |
| 3. SEX <i>F</i> | 4. RACE <i>Negro</i> | 5. DATE OF BIRTH MONTH DAY YEAR <i>3 21 30</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTO. MD.</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO. MD.</i> |
| 10. CITY OR TOWN OF DEATH <i>BALTO.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>911 Rutland Ave</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Labor</i> 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | |
| 13a. STATE <i>md.</i> | 13b. COUNTY | 13c. CITY OR TOWN <i>BALTO</i> | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>911 Rutland Ave</i> |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Willie Campbell</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Green</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. <i>213-22-144</i> 17. INFORMANT ADDRESS <i>Jacqueline Cook 1005 N. Gray St.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1749</i> IMMEDIATE CAUSE (a) <i>Cardio-respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Breast cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>80</i> to <i>July</i> 19 <i>82</i> , that (we) last saw the deceased alive on <i>June 25</i> 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE DEGREE <i>Allen A Meek MD</i> | | 22c. DATE SIGNED <i>7-8-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALLEN MEEK</i> | | 22e. ADDRESS <i>Johns Hopkins Hospital</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/12/82</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Patricia Butts</i> ADDRESS <i>1029 N. Conokine</i> | | 25a. DATE REC'D. BY REGISTRAR <i>12 1982</i> 25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i> | |

MEDICAL CERTIFICATION



NO 15 1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 4 7 3 REG. NO. | |
|--|--|--|--|--|--|--|--|---|--------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Williams Cook</i> | | | | | 7a. DATE OF DEATH MONTH DAY YEAR <i>7/14/82 7/14/82</i> | | | 7b. HOUR <i>6:40 PM</i> | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>Negro</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>04 05 07</i> | | 6. AGE (WORKING LAST BIRTHDAY) <i>75</i> | | 7c. HOUR | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VIRGINIA</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>US</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> | | 10. MD | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SINAI HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>LABORER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>1805 WALBROOK AVE.</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>UNKNOWN</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <i>230-010-1672</i> | | 17. INFORMANT <i>LOUISE SYKES</i> | | ADDRESS <i>1931 MONTROSE ST.</i> | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ca of lung.</i> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca of lung.</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5/14 82</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/14 82</i> to <i>7/14 82</i> that (I) (we) last saw the deceased alive on <i>5/14 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (I did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>E. Edward Dranco</i> MD | | | | DEGREE | | | | 22c. DATE SIGNED <i>7/14/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. EDWARD DRANCO</i> | | | | 22e. ADDRESS <i>3423 Arcadia Dr.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>7-20-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>ARBUTUS MEM PK.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>E. L. PHILLIPS</i> | | | | 1721 N. MONROE ST. | | | | 25a. DATE REC'D. BY REGISTRAR <i>7/15/82</i> | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>E. L. Phillips</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 4 7 4 | | | |
|---|--|--|--|---|--|--|--|
| FOR 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Howard R. Cooper</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 29, 1982</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>June 26, 1924</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9 E. Fort Ave. Balto. Md.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Boiler maker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>B & O R.R.</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Russell --- Cooper</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie --- Reddish</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes W.W. 2</i> | | | |
| 16b. SOCIAL SECURITY NO. <i>214-18-7165</i> | | 17. INFORMANT ADDRESS <i>Mrs. Ethel Cooper, Same as above</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Anaplastic Thyroid Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Marvin J. Feldman</i> | | DEGREE <i>MD</i> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARVIN J. FELDMAN</i> | | 22e. ADDRESS <i>302 Greenspring Station, Lutherville</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>Aug. 2, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A.A. Co. Maryland</i> | |
| 24. FUNERAL DIRECTOR <i>McCutty</i> | | NAME <i>Funeral Home, 130 E. Fort Ave. Balto. Md.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>AUG - 3 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Frances Jean Nathan</i> | |



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

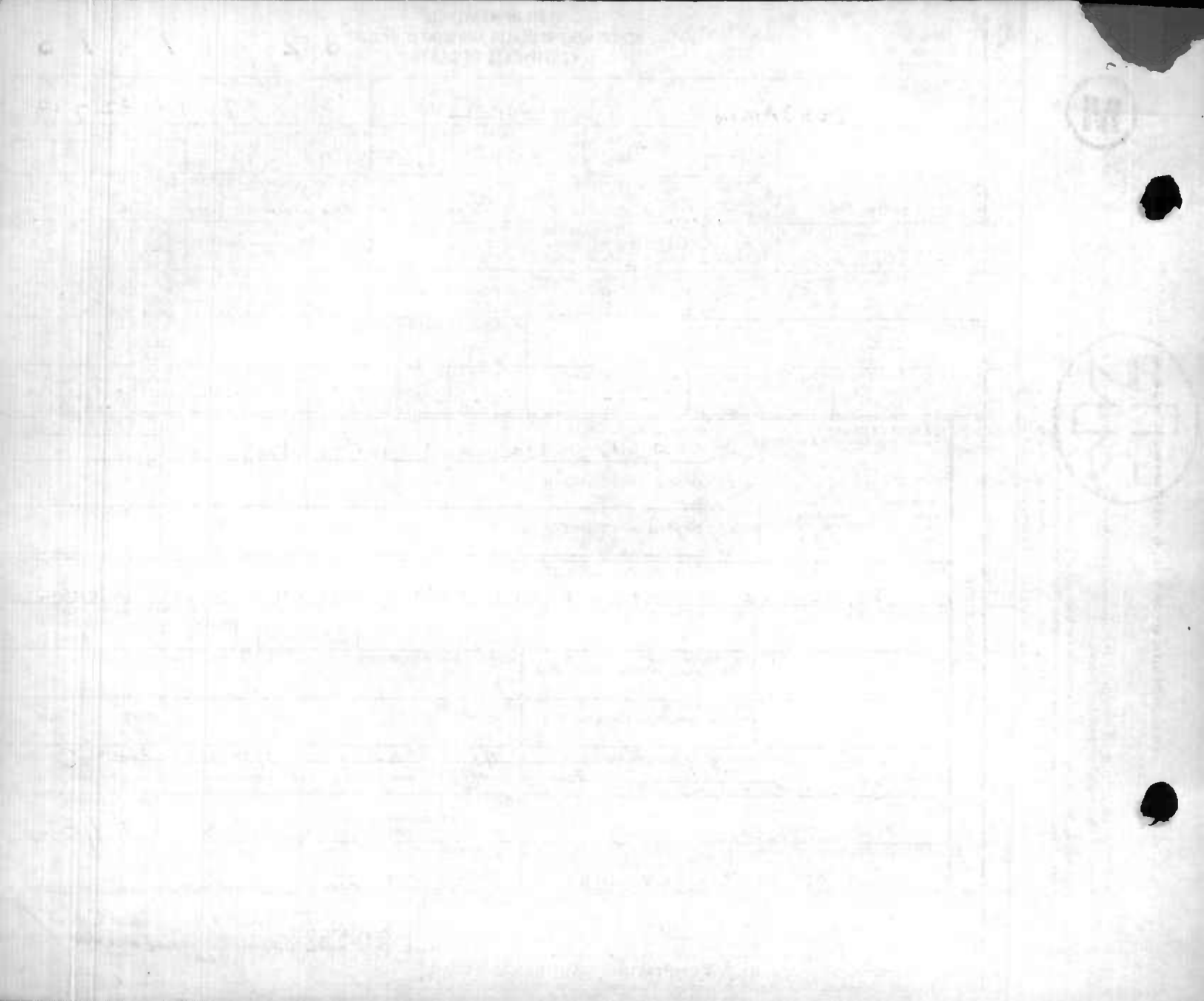
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| | | | | | |
|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN COPPEL | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 82 | | 2b. HOUR 7 29 M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 11, 1901 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 80 | | IF UNDER 1 YEAR MONTHS DAYS YRS. | | IF UNDER 24 HRS HOURS MIN YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) METALLURGIST | | 12b. KIND OF BUSINESS OR INDUSTRY STANDARD OIL | | 13a. STREET ADDRESS WILLOWBROOK APTS. 21209 2909 FALLSTAFF RD. APT. 17 | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MAURICE COPPEL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA LEVINE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 214-01-4183 | | 17. INFORMANT ADDRESS MRS. RENA COPPEL WILLOWBROOK APTS. 21209 2909 FALLSTAFF RD. APT. 17 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4160 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Septicemia, congestive heart failure, peripheral vascular disease | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 82 , to 7/14 , 19 82 , that (I) (we) lost saw the deceased alive on 7/14 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) | | 22b. SIGNATURE Robert M. Cooper MD DEGREE | |
| 22c. DATE SIGNED 7/14/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. COOPER MD | | 22e. ADDRESS SINAI HOSPITAL | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL CEM | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | JUL 20 1982 REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17476 | |
|---|--|----------------------|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) DAVID S. CORBETT, JR. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 7 DAY 5 YEAR 1982 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 8 DAY 29 YEAR 51 | | 6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) pool - 736 Camberley Circle | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3905 W. Forest Park Ave. | |
| 14. FATHER'S NAME FIRST David MIDDLE S. LAST Corbett Sr. | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Lucy MIDDLE Stith LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 219-52-3867 | | | | 17. INFORMANT ADDRESS Lucy Corbett 3905 W. Forest Park Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9840 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7-5- 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Drowned in swimming pool. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) swimming pool | | | | 21f. LOCATION STREET 736 Camberley Circle CITY OR TOWN Balto. COUNTY Md. STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | |
| ACTUAL SIGNATURE Ann M. Dixon | | | | EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | DATE SIGNED 7-5-82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY MD STATE | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | | | 25b. REGISTRAR'S SIGNATURE Shane Jan N... | | | |

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[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 4 7 7 REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Elihu W. (F) Corbin</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7/1/82</i> | | 2b. HOUR <i>5:45</i> P.M. | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 27 18</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>1737 N. Moreland Avenue</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>unkn</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>unkn</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>223-26-7663</i> | | 17. INFORMANT ADDRESS <i>Elizabeth Corbin 1737 N. Moreland</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>5751</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metabolic disorders</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>sepsis</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i>5/31/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cholangitis</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/30/82</i> 19 <i>82</i> to <i>7/1</i> 19 <i>82</i> , that (I) (we) last saw the deceased give on <i>7/1/82</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>E. Harland</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>7/1/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Nastlund</i> | | | | 22e. ADDRESS <i>Balt. City Hosp.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/7/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Pk.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Co. MD</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Wm. C. March F/H 1101 E. North Ave</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 6 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Marie Jean North</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 4 7 8 | |
|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| CHARLIE (CHARLES) CORNWELL | | | JULY 7-2-82 | | 11:20 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR |
| MALE | NEGRO | MONTH DAY YEAR 4-9-17 1917 | 65 YRS. | | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| SOUTH CAROLINA | USA | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | ST. AGNES HOSPITAL | | LABORER | | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? |
| MARYLAND | | | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST ALLEN CORNWELL | | | FIRST MIDDLE LAST AMY HILL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
| NO | | | 218-05-1146A | 256 NORTH HILTON STREET | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CA LUNG STAGE II WITH BILATERAL</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>INFARCTS OF OCCIPITAL + FRONTAL LOBE.</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE P.V. Kanani | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Kanani, M.D. | | 22e. ADDRESS 900 SO CATON AVE. BALTO., MD. 21229 | | 7-2-82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | 23e. STATE |
| BURIAL | | 07/07/82 | ARBUTUS MEM PARK | BALTIMORE BALTO | MD. |
| 24. FUNERAL DIRECTOR MARSHALL W JONES, JR/4101 | | | 25a. DATE REC'D. BY REGISTRAR | | |
| EDMONDSON AVE | | | JUL 7 1982 | | |
| | | | 25b. REGISTRAR'S SIGNATURE James Jan Nathan | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO VITAL RECORDS 8/11/82
STATE REGISTRARItems 1 & 2 per phone 8/17/82
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 4 7 9
REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) PAULINE CORRIGAN | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/31/82 | | 2b. HOUR MIN 6:20 AM |
| 3. SEX FEMALE | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee | 7b. CITIZEN OF WHAT COUNTRY? US citizen | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 307 S. Fulton Ave., 21223 |
| 14. FATHER'S NAME FIRST MIDDLE LAST J. E. Perryman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 112 22 6969 | | 17. INFORMANT ADDRESS Robert Dougherty, Esq. 28 Allegheny Ave. Towson, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest 5698 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of sigmoid colon & fecal DUE TO, OR AS A CONSEQUENCE OF (c) peritonitis and septic shock APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION 7/31/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforation of colon | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 30, 1982 to July 31, 1982 , that (I) (we) last saw the deceased alive on July 31, 6:15 AM, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Charles S. White | | DEGREE MD | | 22c. DATE SIGNED 7/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES S White | | 22e. ADDRESS St Agnes Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | 23b. DATE 8/10/82 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR AUG 11 1982 | 25b. REGISTRAR'S SIGNATURE John J. Connel |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|---|------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 4 8 0 | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Mae Costley | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 06 82 | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 03 25 30 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 3 11 | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4006 Maine Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond Costley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Myers | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-28-5401 | | 17. INFORMANT ADDRESS Herman F. Costley, Jr., 859 Streaker Rd., Sykesville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5718 IMMEDIATE CAUSE (a) Rupture of Esophageal Varices DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 04, 19 82, to July 6, 19 82, that (I) (we) last saw the deceased alive on July 6, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE MING CHANG | | | | | DEGREE | | 22c. DATE SIGNED 07-06-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MING CHANG | | | | | 22e. ADDRESS SINAI HOSPITAL of Baltimore | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-9-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Fairview | | 23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md. | | | |
| 24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md. | | | | | 25a. DATE FILED BY REGISTRAR JUL 9 1982 | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR Percy Benson COURTNEY CERTIFICATE OF DEATH REG. NO. 8 2 1 7 4 8 1 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) PERCY Benson COURTNEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-13-82 07 13 82 2b. HOUR 11:55 PM | | | | |
| 3. SEX M Male | | 4. RACE C White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 7 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 69 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS 07 13 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Steel Mill | |
| 13a. STATE Maryland 13b. COUNTY --- 13c. CITY OR TOWN Baltimore | | | | | 13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/> | | 13e. STREET ADDRESS 126 S. Calhoun St. 21223 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George A. Courtney | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna May Ellwell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. WW-II 215-09-0988 | | 17. INFORMANT ADDRESS Iona M Courtney/126 S Calhoun St/Balto Md 21223 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure. DUE TO, OR AS A CONSEQUENCE OF (b) myocardial ischemia (c) coronary artery disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | |
| 19a. DATE OF OPERATION 7-13-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED coronary artery disease | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7 19 82 , to 7-13 19 82 , that (I) (we) lost saw the deceased alive on 7-13 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lyni Farnes, M.D. DEGREE ATTENDING PHYSICIAN MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 7-13-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lyni Farnes | | | | | 22e. ADDRESS University Hospital | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 07/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland 21229 | | | |
| 24. FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets ADDRESS Balto Md 21223 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 SIGNATURE [Signature] | | | | |



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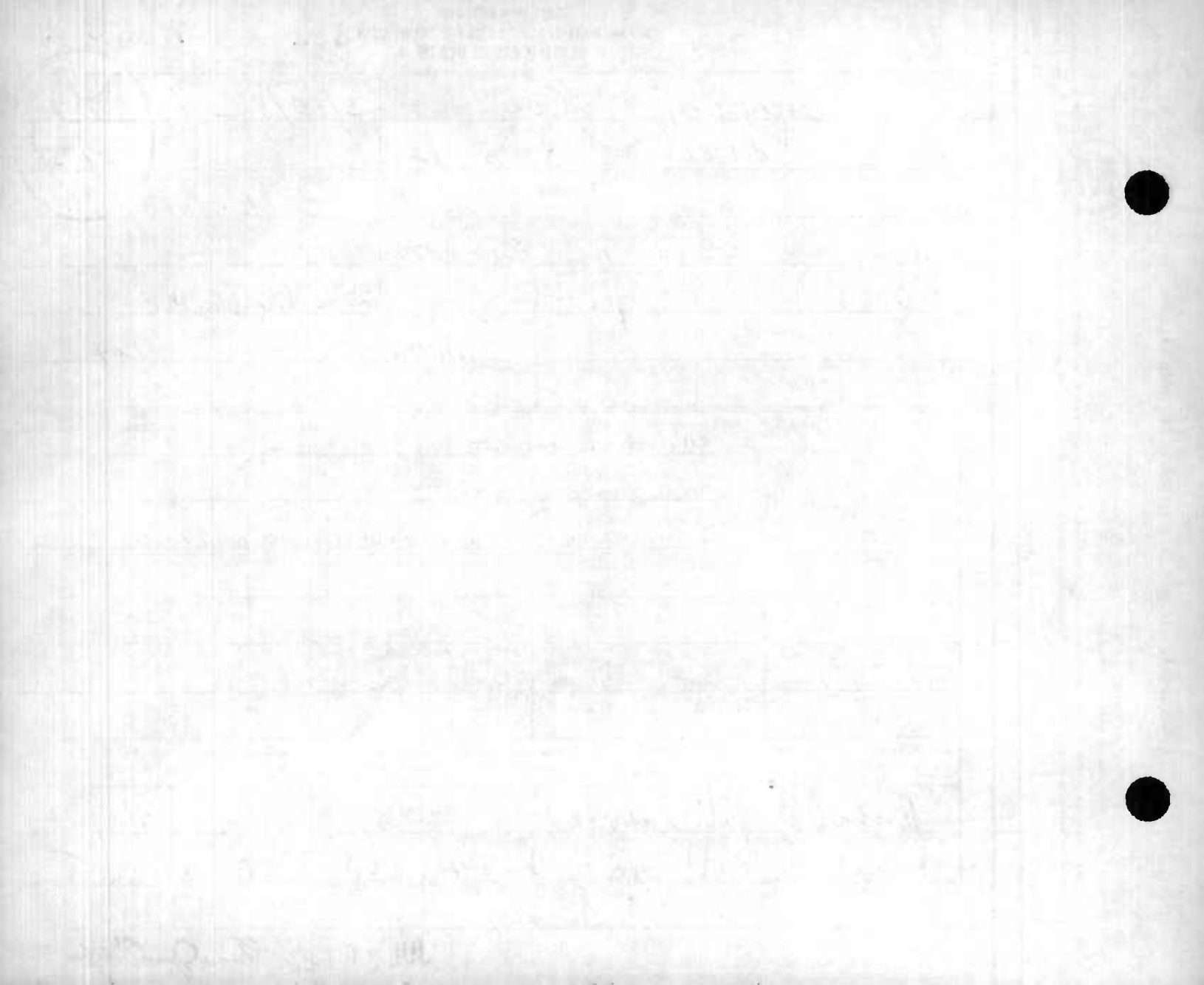
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---------------------------------------|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | 8 2 1 7 4 8 2 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| BABY BOY COX | | | | | 5/15/82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| MALE | | BLACK | | J 15 82 | | YRS MONTHS DAYS | | 4 25 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | Balt. City | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balt | | SINAI Hosp. Baltimore | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| MD | | | | Balt | | | | 2746 Virginia Ave | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | |
| | | | | HATTIE COX | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immature 23w gestation NB with possible infection</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Richard B. Ritterman MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 5/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Richard B. Ritterman | | | | SINAI HOSP, BALT, MD 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| | | | | Sinai | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | | | | |
| | | | | JUL 30 1982 [Signature] | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 4 8 3 | | | |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Michael S.P. Cox</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 1, 1982</i> | | | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 29, 1904</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>410 E. Fort Ave. Balto. Md.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Employee, Balto.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>City</i> | |
| 13a. STATE <i>Maryland</i> | | | | 13b. COUNTY <i>---</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | |
| 14. FATHER'S NAME FIRST <i>Robert</i> MIDDLE <i>---</i> LAST <i>Cox</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Maude</i> MIDDLE <i>---</i> LAST <i>Whitehouse</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>214-01-9180</i> | | 17. INFORMANT ADDRESS <i>Ma. Calvin A. Cox, 6711 Dover Rd. Glen Burnie, Md. 21061</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>3352</i> IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yr.</i> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 1, 1942</i> to <i>June 30, 1982</i> . that (I) (we) last saw the deceased alive on <i>6-30-82</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>A. C. Solled</i> DEGREE <i>MD</i> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>7-2-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Aaron C. Solled M.D.</i> | | | | 22e. ADDRESS <i>707 E. Fort Ave. Balto. Md. 21230</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>July 3, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</i> ADDRESS <i>21230</i> | | | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 REGISTRAR'S SIGNATURE <i>Frances Jan Thorton</i> | | | |

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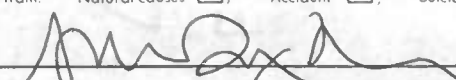
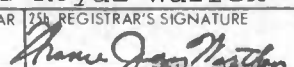
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1905 JUL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | |
|---|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1- FOR ITEM 21c & 22a Film 572 | | | | | | | | | | 7 2 | |
| 1- STATE REGISTRAR 8-23-82 cn | | | | | | | | | | REG. NO. 17484 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Etta Lee CRAIG | | | | | | | | | | 2b. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 31 19 82 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE Maryland | | | | 13b. COUNTY ----- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3612 West Bay Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | 16. ADDRESS Same as # | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 227-22-2489 | | 17. INFORMANT Mr. Richard Craig (HUSBAND) | | 17. ADDRESS 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9550 IMMEDIATE CAUSE (a) Gunshot wound of chest (handgun) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 6:10 P.M. MONTH DAY YEAR 7-31-1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot. Self | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3612 W. Bay Ave. Balto. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 8-1-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 4 AUG '82 | | 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Front Royal Warren VA. | | | |
| 24. FUNERAL DIRECTOR NAME SINGLETON | | | | ADDRESS FUNERAL HOME, GLEN BURNIE, MD. | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE  | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|-------------------|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Ruth MIDDLE: L. LAST: Crater | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 23 82 | | 2b. HOUR 955AM | | | | | | |
| 1. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 16 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balt. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBGH | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. COUNTY MD. | | | | 13b. CITY OR TOWN Baltimore | | 13c. STREET ADDRESS 7719 Trappe Rd. | | | | | |
| 14. FATHER'S NAME (TYPE OR PRINT) FIRST: Alfred MIDDLE: LAST: Yauchter | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST: ELLA MIDDLE: LAST: Coughanour | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 198-18-1229 | | 17. INFORMANT Harry V. Crater | | | | ADDRESS 7719 Trappe Road Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) Refractory CHF and underlying ASCVD DUE TO, OR AS A CONSEQUENCE OF: (c) with several previous MIs | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-16-82 to 7-23-82, that (we) lost saw the deceased alive on 7-23-82, and that in (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michael B. Nestor M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7-23-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Nestor | | | | | | 22e. ADDRESS 3001 S. Hanover | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/26/1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME: Duda-Ruck, Inc. ADDRESS: 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert certificate in pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be retained at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | 8. 2 | | 1. 7 | | 4. 8 | | 6. 6 | |
| 1. DECEASED NAME (TYPE OR PRINT) G. FRANCES CROSWELL | | | | 2a. DATE OF DEATH July 25, 1982 | | | | 2b. HOUR 5:30 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH May 8, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Owings Mills, Md. | | 10. CITIZEN OF WHAT COUNTRY? USA | | 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 13. CITY OR TOWN OF DEATH Baltimore | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Center | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 16. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Md. | | 17b. CITY OR TOWN Balto. | | 17c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 17d. STREET ADDRESS 312 Stevenson Lane | | | | | |
| 18. FATHER'S NAME FIRST MIDDLE LAST Frank D. Gingrich | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva M. Hutchinson | | 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 21. SOCIAL SECURITY NO. 216-07-7777 | | 22. INFORMANT Mrs. Jo Ann G. Raver | | 23. ADDRESS Reisterstown, Md. | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4360 IMMEDIATE CAUSE (a) <i>Probably Cerebral Vascular Accident</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 24a. DATE OF OPERATION | | 24b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 24c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 24d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 26a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 26c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 27. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 28a. SIGNATURE <i>Albert Nahum M.D.</i> | | DEGREE COVENING FOR DR. A. NAHUM | | 28b. DATE SIGNED | | | | | | | |
| 28c. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT NAHUM, M.D. | | 28d. ADDRESS 100 N. B. ROADWAY | | 28e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 29b. DATE July 28, 82 | | 29c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 29d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | | | |
| 30. FUNERAL DIRECTOR NAME Eline Funeral Home | | 30b. ADDRESS Reisterstown, Md. 21136 | | 31. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 32. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| Item 13e Phone 8-12-82cn | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 7 4 8 7 | |
|--|--|--|--|--|--|--|--|
| FOR 1- STATE REGISTRAR | | CERTIFICATE OF DEATH | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST Michael Crowell | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 82 | | 2b. HOUR 4:55 A M | |
| 3. SEX male | | 4. RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 7 22 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 6 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 330 E. Lorraine Ave 21212 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Bowman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wanda Crowell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>electromechanical dissociation</u> 7641 DUE TO, OR AS A CONSEQUENCE OF (b) <u>S/P Blackout for tricuspid atresia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION 7/27/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED tricuspid atresia | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/23/82</u> , 19 <u>82</u> , to <u>7/29</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/29/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>H.P. Hudson, MD</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/29/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) H.P. HUDSON. | | 22e. ADDRESS Univ. MD Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 8/5/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | 25a. DATE REC'D. BY REGISTRAR AUG 10 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Connelley | |
| ADDRESS Balto., Md. | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17488 | |
|--|---------|------------------|---|----------------|------------------|--|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Patrick L. Cullen SR. | | | | | | DATE ESTIMATED 7 18 19 82 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| M | W | 10 22 13 | 68 YRS. | MONTHS | DAYS | 7 18 19 82 | | | 8:23A | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MD. | | | U.S.A. | | | | | | Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 620 S. Luzerne Avenue | | | Ret. | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| MD. | | | | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET ADDRESS | | | | | |
| Patrick Cullen | | | Esther O'Connor | | | Same #11 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | WW II 218-10-8342 | | | DORIS A Cullen | | | Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 4292 | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | | | |
| | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | |
| Hormez R. Guard, M.D. | | | Assistant | | | 7/18/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 111 Penn Street, Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Cremation | | | 7-20-82 | | | Westview | | | Baltimore MD | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| R. Kaczorowski | | | 25a. DATE REC'D. BY REGISTRAR | | | JUL 22 1982 | | | James J. [Signature] | | |

10/13/53

REBIL. UNIT

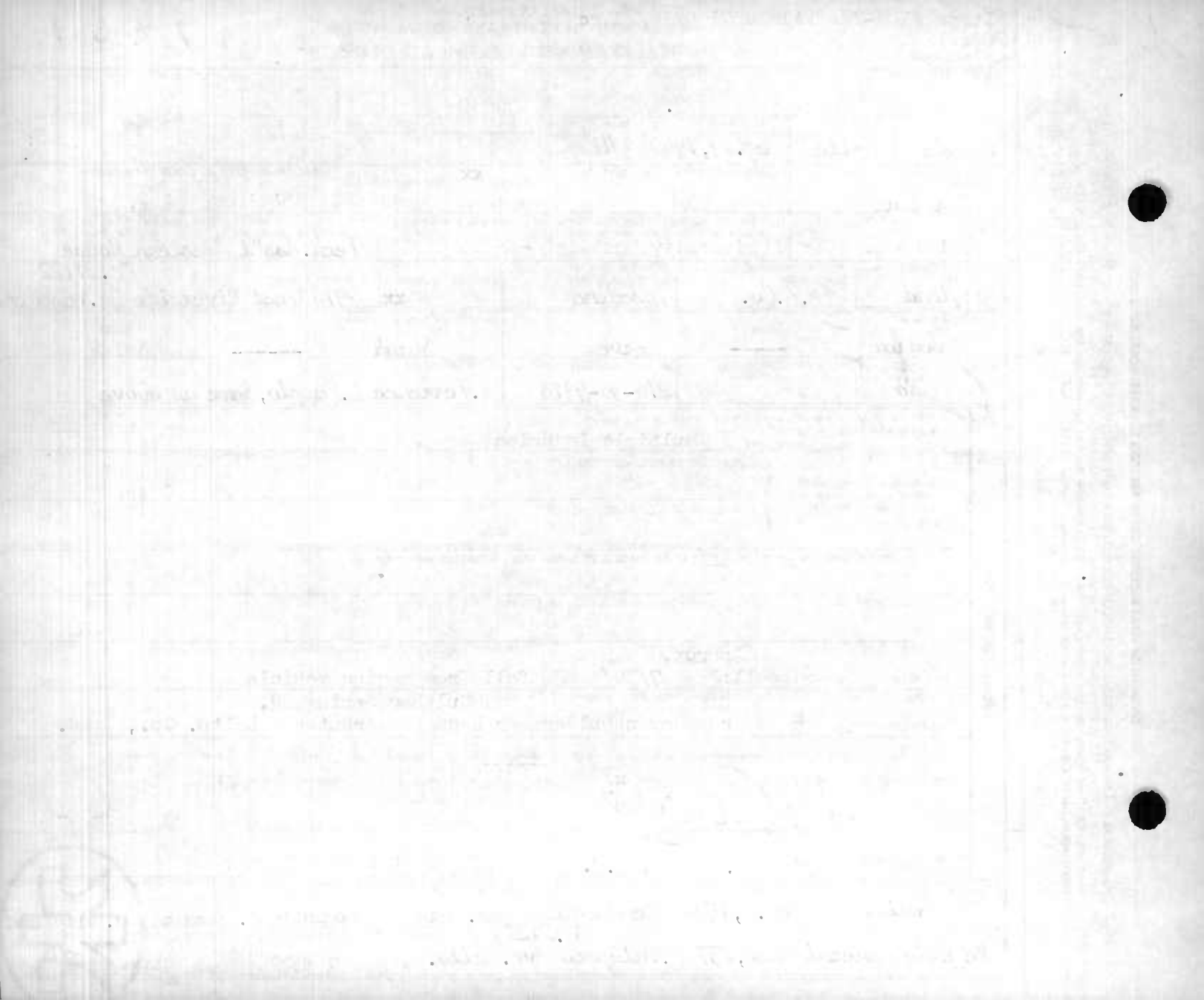
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WIP

10/13/53

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17489 | |
|---|--|---|---|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME (FIRST MIDDLE LAST) Joyce J. Cupplo | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 30 1982 | | | 2b. HOUR M 3:06 a.m. | | | | | |
| 4. RACE Female White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 19, 1940 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 41 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 30 1982 | | 24 HOUR a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tech. Ass't Western House | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY A.A.Co. | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Md. 21122 7916 West Riverside Dr. Pasadena | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Woodrow ----- Harvey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah ----- Smith | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-36-9318 | | | 17. INFORMANT ADDRESS Mr. Terrence L. Cupplo, Same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8189 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 11:23 a.m. 7/30/1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell from moving vehicle | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway shoulder | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sulphur Spring Rd. near Benson Arbutus Balto. Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard | | | TITLE (SPECIFY) Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 7-30-82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Aug. 2, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Rd. Howard Co. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home, 2375 E. Patapsco Ave. Balto. | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | | 25b. REGISTRAR'S SIGNATURE Jan Nathan | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17490

| | | | | | | | |
|--|--------------|---|---|--|--------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME FIRST MIDDLE LAST WARDELL CURREY | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 28 1982 | | 2b. HOUR M 10a | |
| 3. SEX M | 4. RACE N | 5. DATE OF BIRTH MONTH DAY YEAR 2 25 35 | 6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 28 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WARDELL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT Miss Pauline Clinton | | ADDRESS 221 N. Fremont Ave. Apt. 101 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9660 IMMEDIATE CAUSE (a) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10:15 PM 7-27-1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject stabbed. | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION CITY OR TOWN COUNTY STATE 200 blk. N. Fremont Ave., Balto. City Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7-28-82 | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. Md. | |
| 24. FUNERAL DIRECTOR NAME Patricia Betts | | ADDRESS 1129 N. Caroline St. | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

MADE IN
U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. The law requires that the death certificate be signed by the attending physician and completed by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | REG. NO. 8 2 1 7 4 9 1 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE SIMON CURRY | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 3, 1982 | | 2b. HOUR 3:01a | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 11 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Curry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Massenberger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216-12-7279 | | 17. INFORMANT ADDRESS James Curry 1312 Ashland Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST. 1509 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CANCER | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3 19 82 , to 7/3 19 82 , that (I) (we) lost saw the deceased die on 7/3 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Andrew Beamer MD DEGREE 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW BEAMER | | | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22e. DATE SIGNED 7/3/82 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 25b. REGISTRAR'S SIGNATURE James Curry | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a medical investigation will be conducted.

DHMH-16 50M 1/81
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARITA F CURRY | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 10 82 | | 2b. HOUR 9:35 AM |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 11 8 19 | 6. AGE (IN YEARS LAST BIRTHDAY) 63 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (COUNTRY) VA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY — |
| 13a. STATE MD | 13b. COUNTY BALTO CITY | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Morris | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANNIE CAAEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-34-2441 | | 17. INFORMANT ADDRESS Lula Curry 2127 1704 Harlem Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) heart failure DUE TO, OR AS A CONSEQUENCE OF (c) possible MI | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — — — 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 9 , 19 82 , to July 10 , 19 82 , that (I) (we) last saw the deceased alive on July 10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death. | | | | | |
| 22b. SIGNATURE Linda Headrick MD | | DEGREE MD | | 22c. DATE SIGNED 7/10/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Linda Headrick MD | | 22e. ADDRESS 225 Greene St, umh | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/14/82 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Ave. | | 25a. DATE RECEIVED BY STATE REGISTRAR JUL 13 1982 | |

25b. DATE RECEIVED BY COUNTY REGISTRAR
James Jan Nathan



CHACH

CLARENCE

ALL 34-3441 (copy) 1904 11-10-1904

Wm. C. LARSON (H. 101 E. North Ave.
Omaha, Neb. 68102)
J. H. 187 (copy) Hill Co. Ill.
D. 11/15/04

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST LAURA VIRGINIA CURTIAN | | | | | MONTH DAY YEAR HOUR 07 05 82 7 P M | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| F | | W | | MONTH DAY YEAR 10 17 03 | | 78 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Md. | | U. S. A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | St. Agnes Hospital | | | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2627 Lehman St. #21223 | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Charles Shipley | | | | | FIRST MIDDLE LAST Mary | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| | | 219-74-4765 | | 2686 Dulaney St. #21223 Donald Curtian | | | | | |
| 18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of Liver with Polycythemia with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure with Hypertension & Colic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE P. V. Kanani | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7-5-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. Kanani, M.D. | | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md. | | |
| 24. FUNERAL DIRECTOR G. Truman Schwab, P.A. | | | | | 25. REGISTRAR'S SIGNATURE JUL 12 1982 | | | | |



RECEIVED
JUL 11 1964
U.S. AIR FORCE
HONOLULU, HAWAII

JUL 11 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17494 | |
|---|-------------------------|---|---|---|---|---|---|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DONALD W. CURTIS | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 7 DAY 16 YEAR 1982 | | 7b. HOUR 5:35 | | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 6 DAY 8 YEAR 38 | 6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7 16 1982 | | 7d. HOUR 5:35 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3606 W. Garrison Avenue | | | |
| 14. FATHER'S NAME FIRST William MIDDLE LAST Curtis | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE J. LAST Jones | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-36-1609 | | 17. INFORMANT ADDRESS Eloise Green 3606 W. Garrison Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9804 IMMEDIATE CAUSE (a) Drug overdose Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7/12/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) unknown | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown | | 21f. LOCATION STREET Unknown CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE H R Guard | | | TITLE (SPECIFY) M.D. | | | | MEDICAL EXAMINER Hormez R. Guard, M.D. | | DATE SIGNED | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | ADDRESS 111 Penn Street, Baltimore, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE MD | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR FOR PAGE 4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17495

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|-------------------|--|--|-----------|--|--|------------|--|--|-------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST JAMES | | | MIDDLE E | | | LAST CUSTIS | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-19-82 | | | MONTH 7 | | | DAY 19 | | | YEAR 82 | | | 2b. HOUR 10:50 | | | | | | | | | | | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH 1 | | | DAY 31 | | | YEAR 37 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS. | | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | | 7c. DATE PRONOUNCED DEAD 7-19-82 | | | MONTH 7 | | | DAY 19 | | | YEAR 82 | | | 2b. HOUR 10:50 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hempden VA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | MD | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md | | | 13b. COUNTY — | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 4611 Red Zedick Rd #212 | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Joseph | | | MIDDLE — | | | LAST Custis | | | 15. MOTHER'S MAIDEN NAME FIRST Lillian | | | MIDDLE — | | | LAST Smith | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 54660212346159 | | | 17. INFORMANT Lillian Smith | | | ADDRESS 4611 Red Zedick Rd #212 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stabwounds of chest</u> 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:15PM 7-19-82 | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on porch | | | | | | 21i. LOCATION STREET 2207 Linden Avenue CITY OR TOWN Baltimore COUNTY Maryland STATE | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . ACTUAL SIGNATURE <u>Margaret A. Koroll</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <u>Margarita A. Koroll, M.D.</u> ADDRESS <u>111 Penn Street</u> DATE SIGNED <u>7-20-82</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | 23b. DATE July 23 82 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Veteran Cemetery | | | | | | 23d. LOCATION Crownville CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME White | | | | | | ADDRESS 3207 W. Ha | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | | | | 25b. REGISTRAR'S SIGNATURE Frances VanNathan | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
|---|---------|--|------------------|--|---------------------------------|---|-----------------|--|------------------|
| HENRIETTA | | | | CUTLER | 7 | 20 | 82 | 2:12 P.M. | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | | NOV. 17, 1911 | | 70 | | MONTHS | | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE CITY | | N. CHARLES GEN. HOSPITAL | | | | HOUSEWIFE | | AT HOME | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 11 MCMECHEN ST. #21217 | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JACOB | | GINSBERG | | BESSIE MIZRACH | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | | | |
| NO | | 216-24-7299 | | SAUL LEVINE 12822 TEABERRY SILVER SPRING, MD 20906 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 1749 CARDIAC ARREST DUE TO MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY OCCLUSIVE DISEASE 2 years | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF BREAST, BILATERAL since 1962 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) PEPTIC ULCER DISEASE, ANEMIA, INFLAMMATORY CA OF LEFT BREAST | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | — | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | |
| N/A | | HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | | N/A | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| N/A | | N/A | | N/A | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/20/82 to 7/20/82, that (I) (we) lost saw the deceased alive on 7/20/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Christopher V. G. Lamm | | | | | | 7/20/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| QUATMAN VAL HIGANON | | NORTH CHARLES GENERAL HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | JULY 22, 1982 | | SHOMREI HADATH VE TZEMECH | | ROSEDALE | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | | | | | | |
| NAME SOL LEVINSON & BROS., INC. | | JUL 23 1982 | | | | | | | |
| 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | | | | |



RECEIVED
JUL 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 4 9 7 | |
|--|--|---|---|--|--|
| 1- FOR STATE REGISTRAR Eugene B. Czolba | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) EUGENE BERNARD CZOLBA | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 20, 1982 | | 2b. HOUR 12:23 A.M. |
| 1. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR AUG - 20, 1935 | | 6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO. BALTIMORE GEN. HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSEMBLY | 12b. KIND OF BUSINESS OR INDUSTRY G. MOTORS |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | 13b. CITY OR TOWN A.A. BALTO. | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 5254 4th ST. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM G. CZOLBA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERONICA K. BLACHOWICZ | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 1955-1957 217-30-3965 | | 17. INFORMANT ADDRESS (21061) TERRACE AGNES CZOLBA 8069 LONGBRANCH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE Cause (a) Early myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) A.S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary congestive failure. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 19, 1982 to JULY 20, 1982 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Sol Witkiol, M.D. | | DEGREE | | 22c. DATE SIGNED 7/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL WITKIOLO, M.D. | | 22e. ADDRESS 3301 So. HANOVER ST. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/24/82 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. |
| 24. FUNERAL DIRECTOR NAME BALTO., MD. 31225 GONCE F.H. 4001 RITCHIE HWY. | | | 25a. DATE REC'D BY REGISTRAR JUL 23 1982 | | |

BP

OFFICE OF THE SECRETARY OF DEFENSE

ATTENTION: PERSONNEL

(10)

TO: THE SECRETARY OF DEFENSE

FROM: [illegible]

X

PERSONNEL

SECRETARY

DEFENSE

10-10-50

10-10-50

SECRETARY

DEFENSE

10-10-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 4 9 8

REG. NO. 1

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Matthew</u> MIDDLE <u>Matthew</u> LAST <u>Dallas</u> | | 2a. DATE OF DEATH MONTH <u>7</u> DAY <u>14</u> YEAR <u>1982</u> | | 2b. HOUR <u>9⁰⁶</u> P.M. | |
| 3 SEX <u>Male</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH MONTH <u>4</u> DAY <u>20</u> YEAR <u>03</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Scotland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10 CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hospital</u> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Steel Worker</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u> | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Dundalk</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME FIRST <u>Matthew</u> MIDDLE <u></u> LAST <u>Dallas</u> | | 15 MOTHER'S MAIDEN NAME FIRST <u>Alice</u> MIDDLE <u></u> LAST <u>Ferguson</u> | | 13e. STREET ADDRESS <u>253 St. Helena Avenue</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>213-09-4165</u> | | 17 INFORMANT <u>Tillie G. Dallas</u> | | ADDRESS <u>253 St. Helena Ave. Balto., MD. 21222</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>4416</u> IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u></u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u></u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>S.L. Rowen MD</u> | | DEGREE <u></u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/14/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S.L. Rowen MD.</u> | | 22e. ADDRESS <u></u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>7/17/1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u> | | 23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE <u></u> | |
| 24. FUNERAL DIRECTOR NAME <u>Duda-Ruck, Inc.</u> ADDRESS <u>7922 Wise Avenue Dundalk, MD. 21222</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 19 1982</u> 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | |

PT 20 22 F 11/16 21.1 11/1

11/16 21.1 11/1

11/16 21.1 11/1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Robert

H.

Dalton Jr.

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 7 24 19 82 2b. HOUR M 10:20

3 SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

MONTH DAY YEAR 7 24 19 82

2d. HOUR M 10:20

Male

White

Aug. 10, 1965

16 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City, MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Student

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

-

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4412 Colmar Gardens Dr. Apt E.

14. FATHER'S NAME

Robert H. Dalton Sr

15. MOTHER'S MAIDEN NAME

Nancy Johnson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

-

17. INFORMANT

ADDRESS

Nancy and Robert Dalton

Same

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

8147

IMMEDIATE CAUSE (a) Cranio cerebral trauma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

5:50 P.M. 7 21 1982

pedestrian struck by auto

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

street

3100 Blk. N. Charles St., Baltimore City, Md.

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from: Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D. Deputy Chief MEDICAL EXAMINER

DATE SIGNED 7/25/82

EXAMINER'S NAME (TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

7/28/82

23c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Woodlawn Balto. Maryland

24. FUNERAL DIRECTOR

NAME

ADDRESS

Burgee Funeral Home 3631 Falls Road 21211

25a. DATE REC'D. BY REGISTRAR

JUL 28 1982

REGISTRAR'S SIGNATURE

James J. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 1 7 5 0 0 REG. NO. | | | | | |
|---|--|--|--|---|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST D'Amico Joseph | | | | | 7-14-82 1:07 PM | | | | | |
| 3. SEX MALE | | 4. RACE CAU. | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 28/06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 yrs. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker | | 12b. KIND OF BUSINESS OR INDUSTRY Beer | | |
| 13a. STATE MD. | | | | | 13b. COUNTY Balto | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Damico | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liotta Antoinina | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] WWI Coast Guard | | | | | 16b. SOCIAL SECURITY NO. 219/10/4316 | | 17. INFORMANT ADDRESS EVA DAMICO 907 TRINITY ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) infection - prob pneumonia DUE TO, OR AS A CONSEQUENCE OF: (b) aspiration DUE TO, OR AS A CONSEQUENCE OF: (c) CPR after cardiopulm. resuscitation 7 5070 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Etiology of cardiac resp. arrest unknown - presumed M.I. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10, 1982, to 7/14, 1982, that (I) (we) lost saw the deceased alive on 7/14, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J. BAER MD | | | | DEGREE | | | 22c. DATE SIGNED 7/14/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. BAER MD | | | | 22e. ADDRESS MERCY HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD. | | | | |
| 24. FUNERAL DIRECTOR NAME Deek Rose & Son Funeral Home | | | | ADDRESS 322 S. High St. | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Wathen | | |

83-51-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit requires carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 5 0 1 | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST NORMA Barbara DAMMANN | | | | MONTH DAY YEAR 7-13-82 | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 9, 1928 | | 6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH C. Ty. MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | |
| 13a. STATE Md | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13e. STREET ADDRESS Raynor Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Henry Ernest Mummert | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Klein | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214 24 3811 | | 17 INFORMANT ADDRESS Paul M. Dammann 3243 Chestnut Avenue 21211 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL FAILURE 5850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-31 , 19 82 , to 7-13 , 19 82 , that (I) (we) last saw the deceased alive on 7-13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John A. Covington DEGREE MD | | | | 22c. DATE SIGNED 7/13/82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Covington | | | | 22e. ADDRESS Westview Mem. Hosp | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Westview Balto. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Burgee Funeral Home 3631 Falls Road 21211 | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 19 1982 Thomas J. [Signature] | | | |

June 7, 1952

White

White

USA

USA

Internal Security

Internal Security

Exhibition

by

Rebel Alliance

Henry Street Museum

May 24, 1951

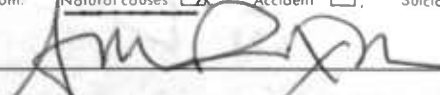
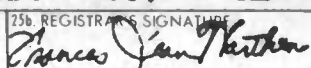
0

2/18/52

Exhibition

Three internal one 3031 also one 3121

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17502 | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NELL DANIELS | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 7 DAY 5 YEAR 1982 | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH 7 DAY 5 YEAR 1982 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 231 N. Monroe St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 231 N. Monroe St. | | | |
| 14. FATHER'S NAME FIRST Isaac MIDDLE LAST McDaniels | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Harriett MIDDLE LAST Daniels | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 219-32-4942 | | 17. INFORMANT ADDRESS Theodore Daniels 231 N. Monroe St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Metastatic carcinoma of bladder DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-6-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | |

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RECEIVED BY THE AMERICAN CONSUL IN LONDON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | Add.info File G570 | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | CERTIFICATE OF DEATH | | 8 2 1 7 5 0 3 | | REG. NO. | |
|--|--|--------------------|--|---|--|---|--|---|--|---------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | | HOURS MIN. | | | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | | | 7. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | 13. STREET ADDRESS | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT OR CONTINGENT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION (CITY OR TOWN, STREET, BOX NO., APARTMENT NO., ETC.) | | | | | |
| 22a. CERTIFY THAT (I) (this hospital) attended the deceased from above, (II) (we) (did not) view the body after death. | | | | 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | |
| 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (CITY OR TOWN, STREET, BOX NO., APARTMENT NO., ETC.) | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17504 | | | |
|--|--|--------------------|---|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) RACHEL | | | FIRST AKA MIDDLE DARGIN LAST DARGAN | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 7-10-82 | | MONTH 7 DAY 10 YEAR 82 | | 7b. HOUR 7:32P | | | |
| 3. SEX Female | | 4. RACE Col | | 5. DATE OF BIRTH MONTH 9 DAY 29 YEAR 1921 | | 6. AGE (IN YEARS) LAST BIRTHDAY 60 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN. 0 | | 2c. DATE PRONOUNCED DEAD MONTH 7 DAY 10 YEAR 82 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penned Co. Md | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) - 301 N. Carrollton Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. STATE Maryland | | | 13b. COUNTY BALTO. | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 301 N. Carrollton Ave | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE DARGAN LAST DARGAN | | | 15. MOTHER'S MAIDEN NAME FIRST Tinnie MIDDLE Simpson LAST Simpson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 242-32-0013 | | | 16c. INFORMANT ADDRESS Mrs. Olivia Holmes 2909 Windsor Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1990 Carcinomatosis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-13-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gmt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lansdown Gmt. | | | | | |
| 24. FUNERAL DIRECTOR NAME Joseph L. Russ | | | | ADDRESS 2222 W. North Ave. | | 25. DATE RPT. BY REGISTRAR JUL 19 1982 | | REGISTRAR'S SIGNATURE [Signature] | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 0 5

REG. NO.

| | | | | | | | | | |
|--|---|---|-------------------|--|---|---|--|------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| ERIC | | | | DAVID | JULY 1, 1982 | | | | 11 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| MALE | WHITE | MAR. 18, 1917 | | 65 | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| GERMANY | USA | | | BALTIMORE CITY | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | 6527 EBERLE DR. APT. 302 (21215) | | | | RET. PRESIDENT | | TATTLETALE ALARM | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | |
| MARYLAND | | | BALTIMORE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 6527 EBERLE DR. APT. 302 (21215) | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| ADOLPH | | | | ADA | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| YES <input checked="" type="checkbox"/> WWI ARMY | | | | 220-09-4804A | | DAVID Mrs. Bette Stone 6527 Eberle Dr. Apt 302 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> | | | | | | | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Thrombosis</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD + Diabetes Mellitus</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/82</u> to <u>7/1/82</u> , that (I) (we) last saw the deceased alive on <u>6/19/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| <u>Lewis G. Martin MD</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 7-2-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Lewis G. MARTIN | | | | Univ. of Md. Hospital 3A-315 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 7-4-82 | | BNAI ISRAEL CONG. CEM | | BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR'S NAME | | | | 25. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS. | | | | JUL 8 1982 | | <u>[Signature]</u> | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | | | | | | |



Robert C. Martin
4200 + 120000
Governor
Carroll Street

2/5 25/20 45 2/1 85

2012 G. MARTIN House of Rep. 2012-2013
2012 G. MARTIN House of Rep. 2012-2013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 7 5 0 6 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| ALLISON DAVIS | | | | | JULY 18, 1982 | | | 1:29 A M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | | Black | | 7 11 17 | | 65 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| N.C. | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Church Home Hosp. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 217 Beale Ct. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Ed Davis | | | | Little Morgan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | 241-12-0265 | | Elvis Johnson 920 N. Kenwood | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) 4100 CARDIOPULMONARY ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) R/O MYOCARDIAL INFRACTION, SYNCOPY, CHEST PAIN | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 17, 1982, to JULY 18, 1982, that (I) (we) lost | | | | | | | | | |
| saw the deceased alive on JULY 18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| MUKESH LUHAR MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| MUKESH LUHAR MD | | | | | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 7/24/82 | | Baltimore Cem. | | Baltimore | | COUNTY MD | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR SIGNATURE | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | JUL 21 1982 | | [Signature] | |

32

RECEIVED

1915

1915

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE ATTACHED TO THE PERMIT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3

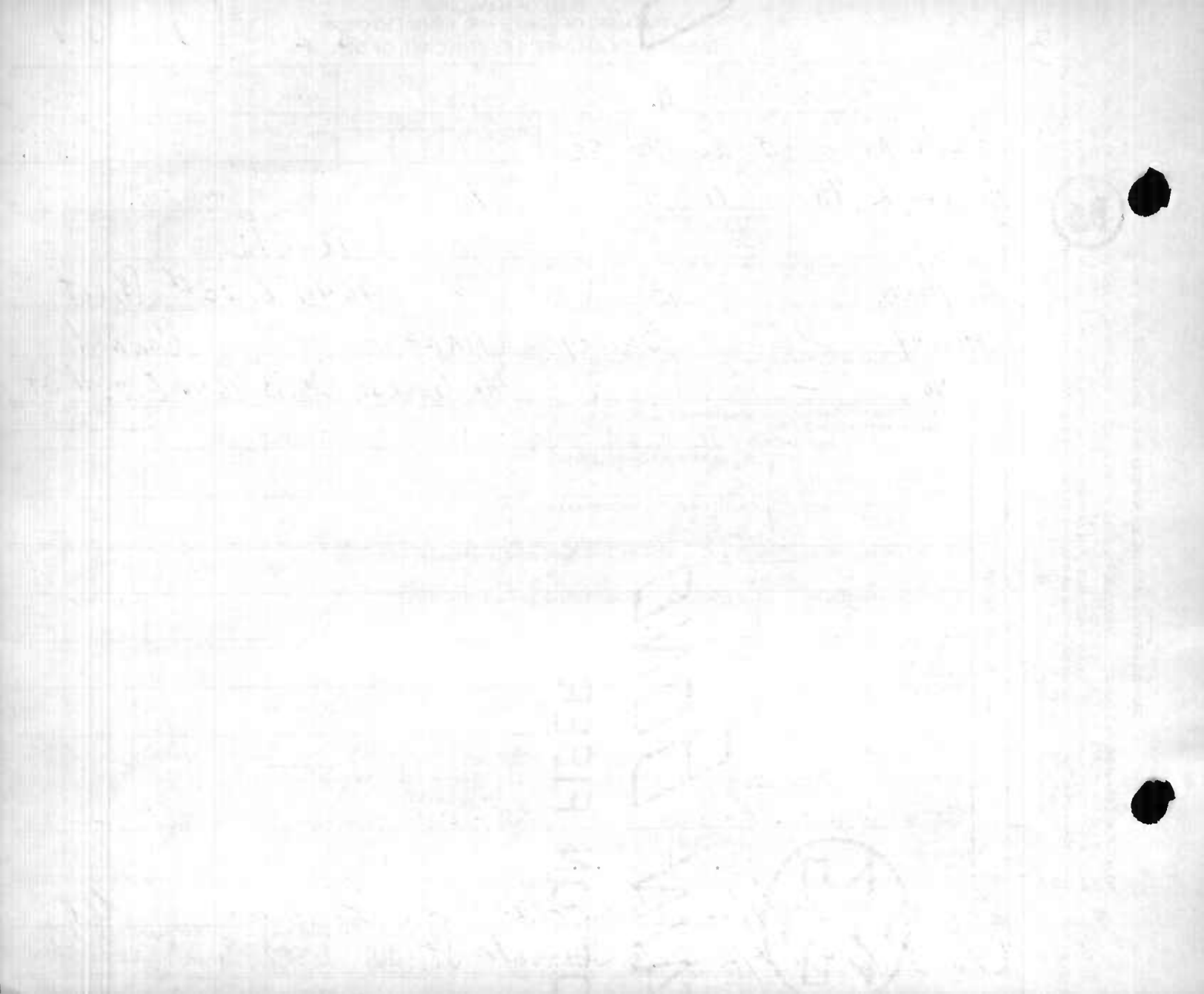
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17507

| | | | | | | | | | | |
|--|------------------|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie E. Davis | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 4 19 82 | | | 2b. HOUR M P.M. 2:35 | | | | |
| 3. SEX Female | 4. RACE Negro | 5. DATE OF BIRTH MONTH DAY YEAR 5 20 19 82 | 6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 4 19 82 | | | 2d. HOUR M P.M. 2:35 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Accomack, Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital - DOA | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 1644 E. 25th Street | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA CANNON | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | | |
| 16a. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS MR. GEORGE DAVIS 1644 E. 25th St. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | | DATE SIGNED 7-6-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Chas. H. Power | | | ADDRESS 7th 519 N. Schroeder St. | | | 25. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Van Wathen | | |



2

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9

9

1602 BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Please do not return to the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|---------------------|---|---|--|---|--|---|---|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Morris</i> MIDDLE <i>Davis</i> LAST <i>Davis</i> | | | 2a. DATE OF DEATH MONTH <i>July</i> DAY <i>16</i> YEAR <i>82</i> | | | 2b. HOUR <i>2:25</i> P.M. | | | | | | | | | | | |
| 3. SEX <i>M</i> | | 4. RACE <i>B</i> | | 5. DATE OF BIRTH MONTH <i>6</i> DAY <i>14</i> YEAR <i>1893</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS. | | 7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | 8. IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MO</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Provident Hosp.</i> | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE <i>MO</i> | | | | | | 13b. COUNTY | | | 13c. CITY OR TOWN <i>Baltimore</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS <i>1129 Calhoun St.</i> | | |
| 14. FATHER'S NAME FIRST <i>Peter</i> MIDDLE <i></i> LAST <i>Davis</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Estelle</i> MIDDLE <i></i> LAST <i>Davis</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>NO</i> | | | | | | 16b. SOCIAL SECURITY NO. <i>N/A</i> | | | 17. INFORMANT ADDRESS <i>779 Concause Vill</i> <i>marquerite Jones Bronx, N. Y.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic Carcinoma</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 6</i> , 19 <i>82</i> , to <i>7-16</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>July 16</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Duck Lae Kim</i> | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DUCK LAE KIM</i> | | | | | | | | 22e. ADDRESS <i>2262 H. Normandy Woods Drive Ellicott City MD 21043</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>7/20/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Mem.</i> | | | | 23d. LOCATION CITY OR TOWN <i>Balto.</i> COUNTY <i></i> STATE <i>MO</i> | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i> ADDRESS <i>1101 E. North Ave.</i> | | | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 20 1982</i> REGISTRAR'S SIGNATURE <i>Thomas San Martin</i> | | | | | | | | | |



1950

X

W. H.

CH

President House

1124 California St.

Baltimore

MD

Catholic

John

1950

1124 California St.
Baltimore, Md.

W. H.

CH

March 1950

March 1950

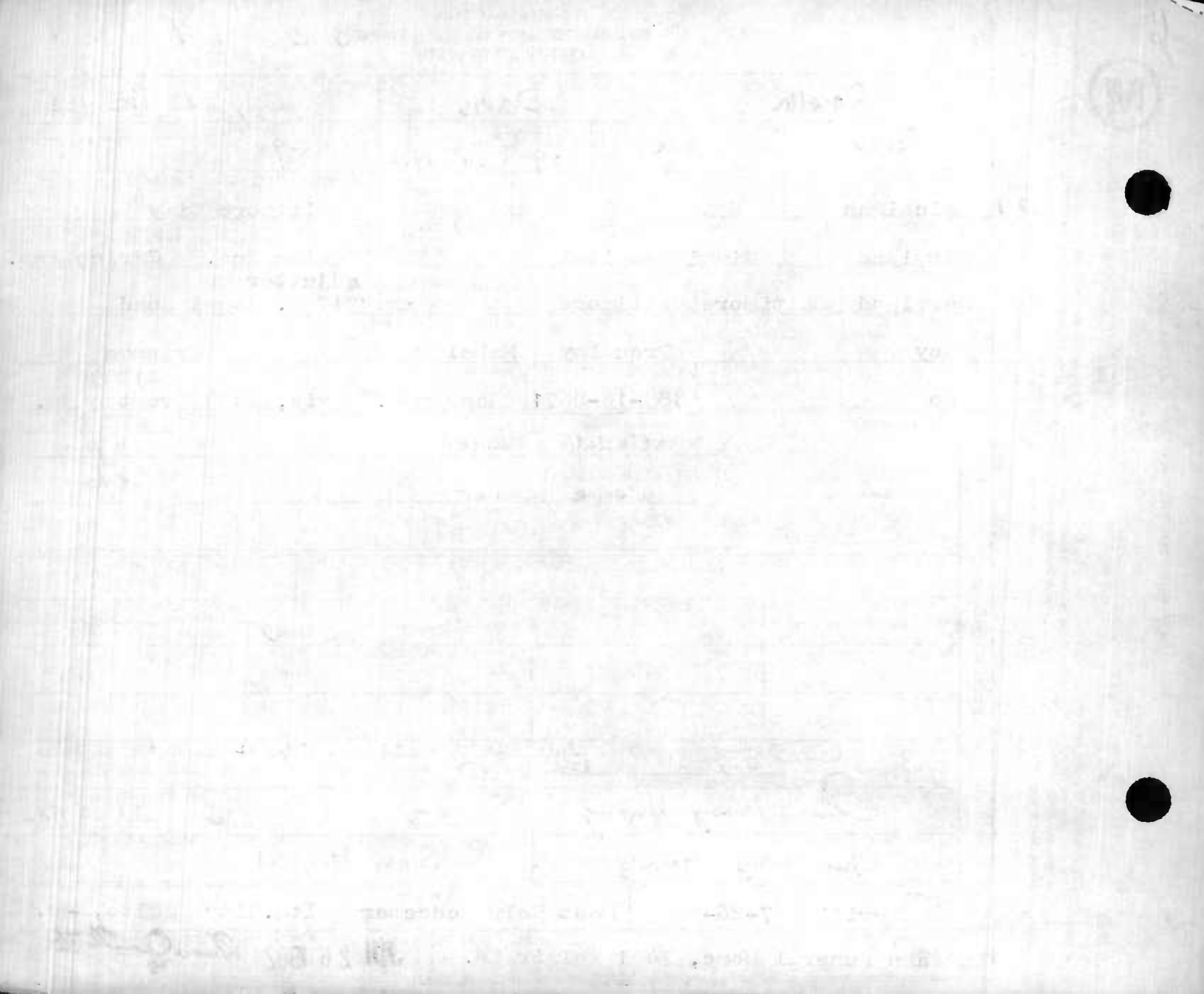


FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rosella Davis | | | 2a. DATE OF DEATH MONTH July DAY 22 YEAR 1982 | | | 2b. HOUR 12A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 09 DAY 20 YEAR 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Harlan Ins. adjustor | | 12b. KIND OF BUSINESS OR INDUSTRY Harlan Ins. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Roy MIDDLE Proudley LAST Mabel | | 15. MOTHER'S MAIDEN NAME FIRST Mabel MIDDLE Ryanson LAST Ryanson | | 16. ADDRESS 2917 E. Uppa Road | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 383-16-0671 | | 17. INFORMANT Ranson J. Davis, 2404 Everton Rd. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1790 IMMEDIATE CAUSE (a) metastatic cancer DUE TO, OR AS A CONSEQUENCE OF (b) uterine cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years 8 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 20 19 82 , to July 22 19 82 , that (I) (we) lost saw the deceased alive on July 21 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Chun-Kang Huang | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED July 22, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chun-Kang Huang | | | | 22e. ADDRESS Sinai Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 23d. LOCATION CITY OR TOWN Balto. City COUNTY Balto STATE Md. | |
| 24. FUNERAL DIRECTOR NAME Lassahn Funeral Home, 7401 Belair Rd. | | | | 25a. DATE REC'D BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR'S SIGNATURE Ranson J. Davis | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles J. Dawson | | | 2a. DATE OF DEATH MONTH DAY YEAR July 7-15-82 | | | 2b. HOUR 3:00 M | | | | |
| 3. SEX M. | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4-24-36 | | 6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 14 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Julius Dawson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Walker | | | 16. STREET ADDRESS 831 N. Fulton Ave | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KORGAN 219-30-4281 | | 17. INFORMANT ANNA N. Dawson | | | | ADDRESS 831 N. Fulton Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fulminant Hepatic failure 2502 DUE TO, OR AS A CONSEQUENCE OF (b) Non-ketotic Diabetic Coma DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (R) Pneumonitis, Urinary tract infection, Chronic alcoholism | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 82 , to 7/15 , 19 82 , that (I) (we) last saw the deceased alive on 7/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I saw) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Bernardo D. Gonzalez Jr. M.D. | | | | | | 22c. DATE SIGNED 7/15/82 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARDO D. GONZALEZ JR | | | | | | 23b. ADDRESS 2800 N. Beeto. Bon Secours Hosp. Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY CROWN HILL VETERANS | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md. Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS MARSHALL W. JONES JR. / 4101 Edmondson Ave / BALTO Md. | | | | | | 25. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 26. REGISTRAR'S SIGNATURE James J. [Signature] | | |

MEDICAL CERTIFICATION

1603 BP

Charles J. Dawson July 1-12-32 34
W Back 1-24-32 46

Maple - DATE 521 N. Fairview

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

Maple 19-20-32 North Washington St. 101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 1 1

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 7 1 82 | | 6 25 AM | |
| EARL ANDREW DEBINSKY | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | Caucasian | | MONTH DAY YEAR 13 25 16 | | 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTIMORE, MD | | USA | | | | BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | South Baltimore General Hospital | | Retired | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | unknown | | 214-26-2567 | |
| John DEBINSKY | | BESSIE HILLER | | 17. INFORMANT | | ADDRESS | |
| | | | | Hospital record chart. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) 1533 | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) TERMINAL Carcinoma of Sigmoid Colon | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | 7.1 19 82, to | | 7.1 19 82, that (I) (we) lost | | | |
| saw the deceased alive on | | 7.1 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 7-1-82 | | | | | | 7-1-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Rosendo Martinez | | SB.G.H. South Hanover St. | | Cremation | | 2 July 82 | |
| | | | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| | | Security Process | | Catonsville Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| James S. Kirkley, Glen Burnie, MD | | | | JUL 6 1982 | | James S. Kirkley | |

NOTION 105

23





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 5 1 2
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) CATHERINE M. DECKER | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 17 82 | | 2b. HOUR 9:50P M |
| 3 SEX FEMALE | 4 RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 06 15 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL - E.R. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAN | | 12b. KIND OF BUSINESS OR INDUSTRY RACE TRACK |
| 13a. STATE MARYLAND | | | 13b. COUNTY --- | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN --- COOKERLY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN I. KELLY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-18-9801 | | 17. INFORMANT ADDRESS CECIL L. DECKER 3318 WASHINGTON BLVD. 21227 | |

| | | |
|---|--|---|
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) H. A. C. V. D. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 30 yrs |
|---|--|---|

| | | |
|--|---|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (the hospital) attended the deceased from January 19 1941 to July 19 82 , that (I) (we) last saw the deceased alive on 15 June 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | |
| 22b. SIGNATURE Herman H. Baylus | DEGREE M.D. | 22c. DATE SIGNED 18 July 82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERMAN H. BAYLUS, M.D. | 22e. ADDRESS 1600 WILKENS AVENUE | |

| | | | |
|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 07-21-82 | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND |
| 24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 20 1982 Frances Santherton | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|--|-----------------|--|--|
| 1. FOR STATE REGISTRAR | | 7 2 1 7 5 1 3 CERTIFICATE OF DEATH REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST FRANK A. DEEMS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 27 82 | | 2b. HOUR 2 p.m. | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Inspector-Balto. City | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3001 Abell Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Adam Deems | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta L. Kahl | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 5362 | | 17. INFORMANT Mrs. Gladys W. Deems, | | | ADDRESS Same | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic HD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min years. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1/2/80</u> , 19 <u>82</u> , to <u>7/27</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>F.M. DUGAN MD</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.M. DUGAN | | | | | 22e. ADDRESS 152 BIDDLE ST BALTIMORE MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Millersville, MD | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | | | |

1000 York Road, Baltimore, Md. 21215
J. Edgar Hoover, Director
Federal Bureau of Investigation
Washington, D. C. 20535

Dear Mr. Hoover:

I am writing to you regarding the matter of the
Union Memorial Hospital, Baltimore, Maryland.
The hospital is located at 1001 West Avenue,
Baltimore, Maryland. It is a large, modern
hospital with a long history of service to the
community. It is a non-profit organization
and is governed by a Board of Directors.
The hospital is currently facing some financial
difficulties and is seeking assistance from
the Federal Government. I am sure that you
will be able to help in some way.

Sincerely,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

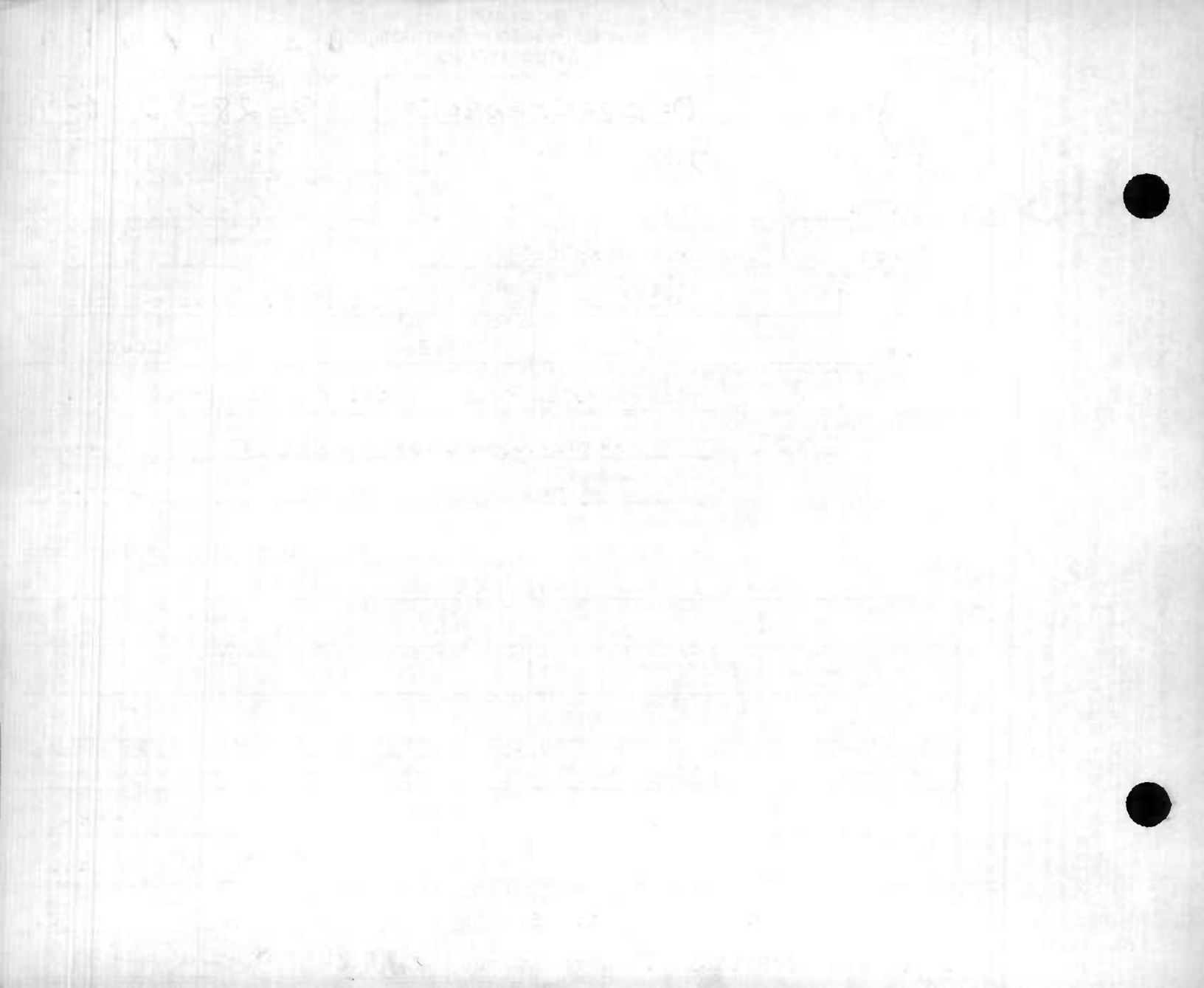
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jessie DEGRAFFENREID | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-28-82 | | | 2b. HOUR 6:25A | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 5 1994 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1621 E. Lanvale Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alex Brice | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Moore | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 249-64-3524 | | 17. INFORMANT ADDRESS Odessa Gatling 5001 Midwood Apt. E3 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST D389 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 24 hr | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/27 , 19 82 , to 7/28 , 19 82 ; that (I) (we) last saw the deceased alive on 7/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE CONDRO | | | | | | DEGREE MD | | 22c. DATE SIGNED 7/28/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONDRO | | | | | | 22e. ADDRESS 44TH HOSP BALTO MD 21216 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7-31-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, no autopsy, injury, or other traumatic event, the medical examiner will not be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 17 513 | |
|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEDRO V. DE LA ROSA | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 08 82 2b. HOUR 4 M | |
| 3. SEX MALE | | 4. RACE LATIN AMERICAN | | 5. DATE OF BIRTH MONTH DAY YEAR 03 11 1896 | |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA | | 7b. CITIZEN OF WHAT COUNTRY? CUBA | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 8. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1302 INVERNESS AVENUE | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | | 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BLACKSMITH | |
| 13b. COUNTY --- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RAMON DE LA ROSA | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLE COSTELLO | | 13e. STREET ADDRESS 2707 WILKENS AVENUE, 21223 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 705-03-9406 | | 17. INFORMANT ADDRESS NORMA E. MICHAEL 1302 INVERNESS AVENUE, 21230 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pump failure DUE TO, OR AS A CONSEQUENCE OF Advanced A.S.C.D. status after myocardial infarction (b) 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last congestive heart failure, renal changes (86 ds) (c) Heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours feems Years. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: old age | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept 14/77 to July 7 82 , that (I) (we) last saw the deceased alive on July 7 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Henry Armanas M.D. | | DEGREE M.D. | | 22c. DATE SIGNED July 9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY ARMANAS, M.D. | | 22e. ADDRESS 1934 WILKENS AVENUE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-10-82 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 9 1982 <i>Anna J. [Signature]</i> | |

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Handwritten notes in the middle section of the page, including the word "SPECIAL" and other illegible text.

Handwritten notes at the bottom of the page, including the word "SPECIAL" and other illegible text.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

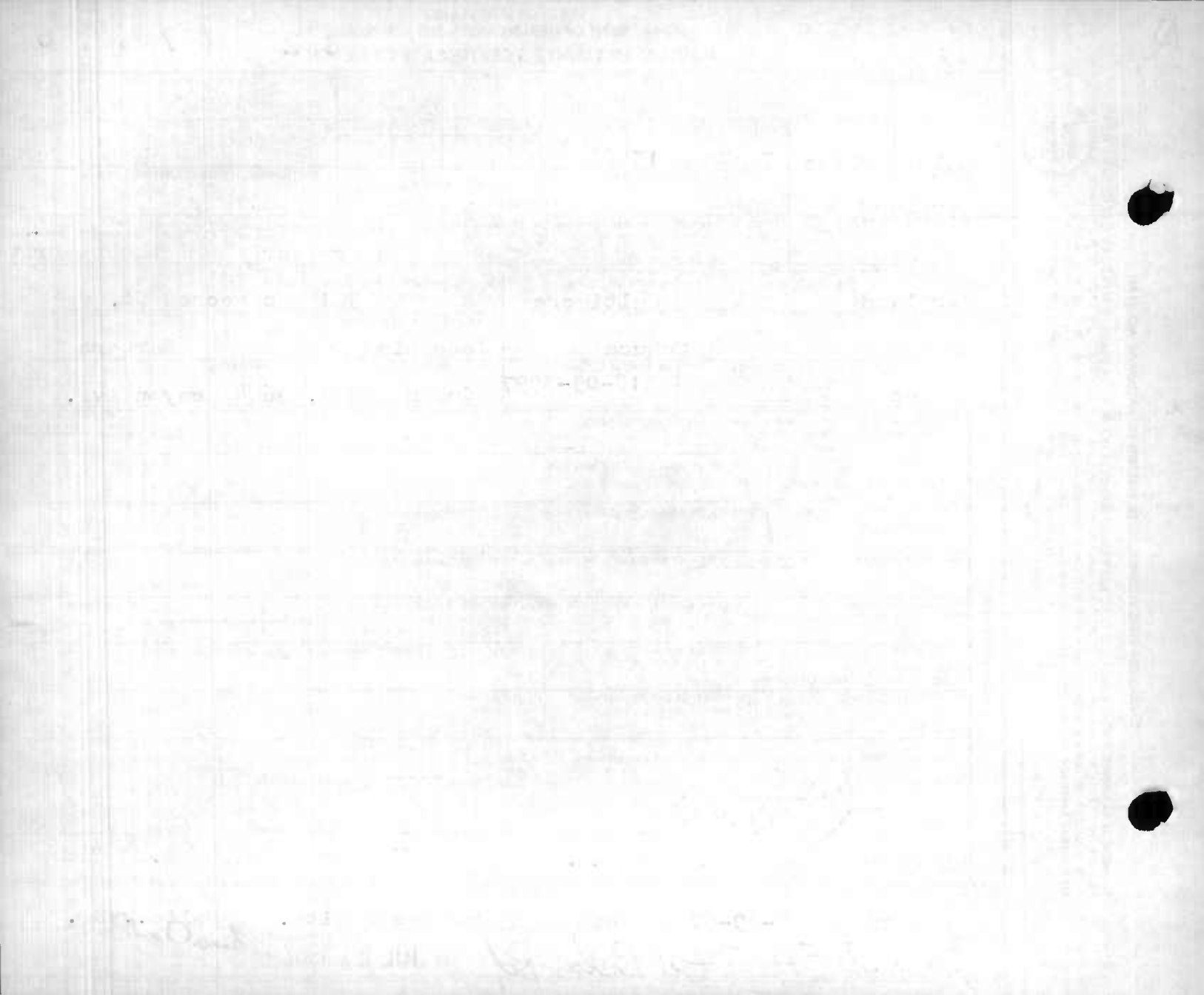
MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17516 | |
|--|--|---|--|--|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Anthony De Luca | | | | | | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 7 15 19 82 | | 2b. HOUR 6:24P | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 7 29 15 66 YRS. | | 6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 301 Mc Mechen Street | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser | | 15. KIND OF BUSINESS OR INDUSTRY Lebow Brot | | | |
| 16a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland | | 16b. COUNTY Baltimore | | 16c. CITY OR TOWN Baltimore | | 16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 16e. STREET ADDRESS 301 Mc Mechen St. | | | |
| 17. FATHER'S NAME FIRST MIDDLE LAST Abraham DeLuca | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Barbera | | | | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 19b. (IF YES, GIVE WAR OR DATES) WW II | | 20. SOCIAL SECURITY NO. 218-05-3997 | | 21. INFORMANT ADDRESS Susan Hagan, 3604 Kenyon Ave. | | | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 23a. DATE OF OPERATION | | | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 23c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 24a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 26a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| 26b. ACTUAL SIGNATURE Hormez R. Guard, M.D. | | | | 26c. TITLE (SPECIFY) Assistant | | 26d. MEDICAL EXAMINER | | 26e. DATE SIGNED 7/16/82 | | | |
| 27a. EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | 27b. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 28a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 28b. DATE 7-19-82 | | 28c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer | | 28d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. MD | | | | | |
| 29. FUNERAL DIRECTOR NAME Lassahn FH | | | | 29b. ADDRESS 7401 Belair Rd | | 29c. DATE REC'D. BY REGISTRAR JUL 21 1982 | | 29d. REGISTRAR'S SIGNATURE [Signature] | | | |

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1401



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MADELL M DEMPSEY | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 25 82 | | 2b. HOUR 6 W A M | |
| 3. SEX F | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5 11 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CLOVER, SC | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) FLO RAYSON ST | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REMEMBERED AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 910 N PAYSON ST | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LUCK CLAWSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUBAN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 52942 6914 | | 17. INFORMANT ADDRESS GEORGE DEMPSEY 910 N PAYSON ST | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4130. <u>CARDIO-PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ANGINA, COPD, H.C.V.D.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NONE</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that on this hospital attended the deceased on 6/16, 19 82, and that in my opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE Howard B. Chen, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN | | MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD B. CHEN, M.D. | | | | | | 22e. ADDRESS DON SECOURS HOSP. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY MONTICENT | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Marshall R. Hays | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE John D. Nathan | | | |

MEDICAL CERTIFICATION

The first of the above is a
 copy of a letter from the
 Secretary of the Board of
 Education to the Board of
 Health, dated January 1st,
 1902. It contains a list of
 the names of the children
 who have been vaccinated
 during the year 1901. The
 list is arranged in alphabetical
 order of the surnames. The
 names are given in full, and
 the date of vaccination is
 also given. The list is
 signed by the Secretary of
 the Board of Education, and
 is accompanied by a certificate
 of the Board of Health, dated
 January 1st, 1902. The
 certificate is signed by the
 Board of Health, and is
 a certificate of the fact that
 the children named in the
 list have been vaccinated
 during the year 1901. The
 certificate is signed by the
 Board of Health, and is
 a certificate of the fact that
 the children named in the
 list have been vaccinated
 during the year 1901.

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 copy of a letter from the
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 who have been vaccinated
 during the year 1901. The
 list is arranged in alphabetical
 order of the surnames. The
 names are given in full, and
 the date of vaccination is
 also given. The list is
 signed by the Secretary of
 the Board of Education, and
 is accompanied by a certificate
 of the Board of Health, dated
 January 1st, 1902. The
 certificate is signed by the
 Board of Health, and is
 a certificate of the fact that
 the children named in the
 list have been vaccinated
 during the year 1901.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 1 8

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR D DESKINS | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 4 82 | | 2b. HOUR 7:55 A M |
| 3 SEX M | 4 RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 08 06 07 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV of Md | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY - | |

| | | | | | | |
|--|--|--|---|---|---|---|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY BALTO CITY | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 625 W. LAFAYETTE AVE |
| 14. FATHER'S NAME FIRST MIDDLE LAST John DESKINS | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY DORSEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-7888 | | 17. INFORMANT ADDRESS Rebecca Deskin 625 W. Lafayette Ave | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 1509 DUE TO, OR AS A CONSEQUENCE OF (b) OBSTRUCTIVE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) ESOPHAGEAL CARCINOMA | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

| | | | | | |
|---|--|---|--|--|---|
| 19a. DATE OF OPERATION 0 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (this hospital) attended the deceased from 6/24, 19 82, to 7/4, 19 82, that (we) last saw the deceased alive on 7/4, 19 82, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.

| | | |
|--|--------|--|
| 22b. SIGNATURE Edward J. Lee MD | DEGREE | 22c. DATE SIGNED 7/4/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD J. LEE | | 22e. ADDRESS 22 S. GREENE ST, BALTO |

| | | | |
|--|---------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/5/82 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD |
| 24. FUNERAL DIRECTOR NAME Leroy A. Sytt 400 Liberty Hgts | | 25. DATE REC'D. BY REGISTRAR JUN 6 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 2 1 7 5 1 9

| | | | |
|---|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| Charles E. Desmond | | MONTH DAY YEAR HOUR 07 24 82 9:15 | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6 AGE (IN YEARS LAST BIRTHDAY) |
| Male | Black | MONTH DAY YEAR 10 23 13 | 68 YRS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| MD | USA | | Baltimore City MD |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |
| Baltimore | Johns Hopkins Hospital | | 12b KIND OF BUSINESS OR INDUSTRY |
| 13a STATE | | 13b COUNTY | 13c CITY OR TOWN |
| MD | | Baltimore | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | |
| Silas Desmond | | Emma Elliott | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b SOCIAL SECURITY NO. | |
| No | | 218-05-1810 | |
| 17 INFORMANT ADDRESS | | | |
| Delores Miller 732 Wharton Ct. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic lung cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Hyperscalcemia</u> | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | |
| 21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>7/16</u> , 19 <u>82</u> , to <u>7/24</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE <u>Drew Pardoll</u> | DEGREE | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c DATE SIGNED <u>7/24/82</u> |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Drew Pardoll</u> | | 22e ADDRESS <u>Johns Hopkins Hospital</u> | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 7/30/82 | Arbutus Mem. Pk. | Baltimore Co. MD |
| 24 FUNERAL DIRECTOR NAME | | 25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE | |
| Wm. C. March F/H 1101 E. North Ave. | | JUL 26 1982 <u>Frances Jean Whithen</u> | |



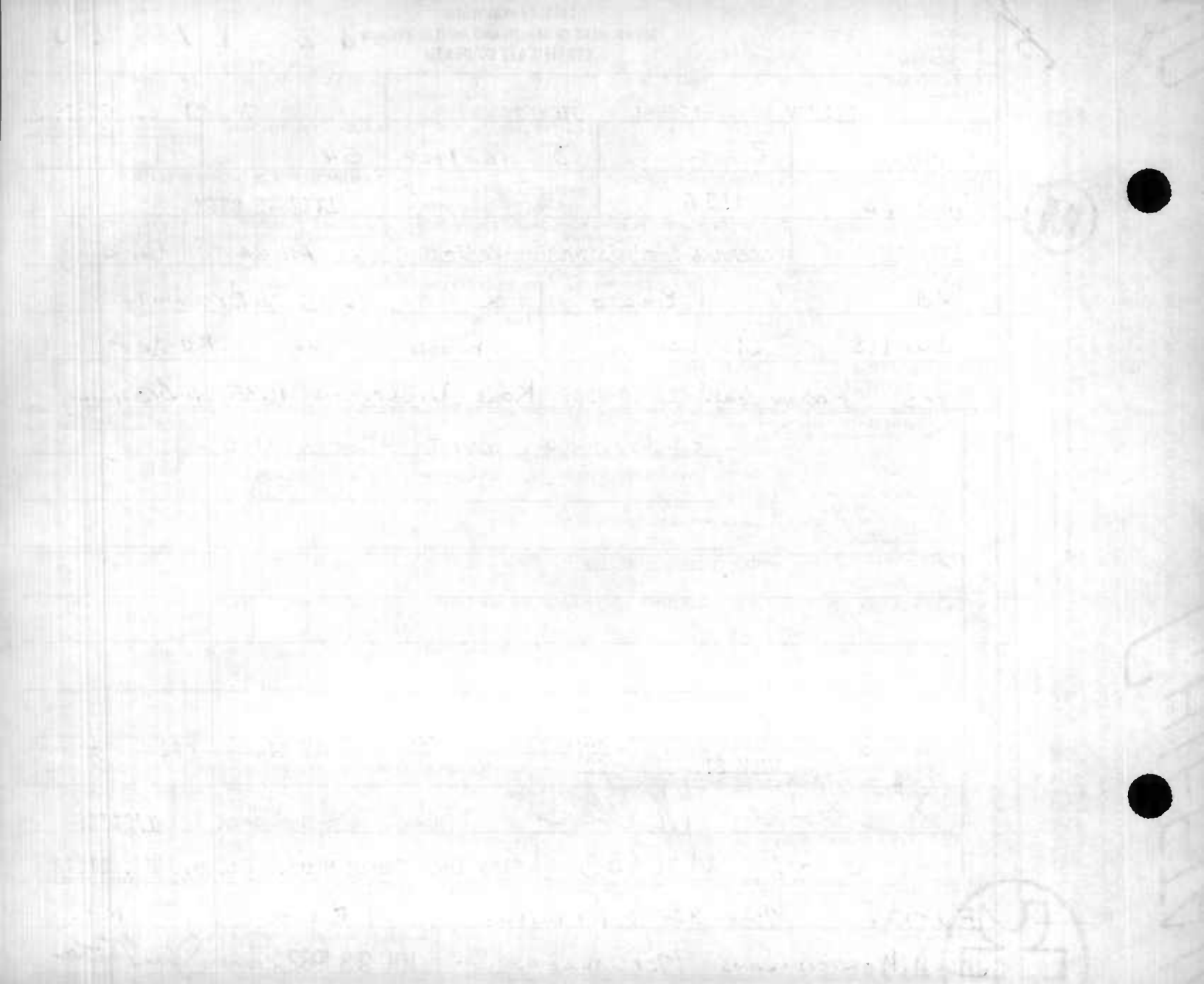
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | 7 2 1 7 5 2 0 | | | |
|--|---|--|---|--|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLORY LIONEL DICKERSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 21 82 | | | 2b. HOUR 12:19 AM |
| 3. SEX MALE | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 3 18 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West VA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Veterans Administration Medical Center | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTENDANT | | 12b. KIND OF BUSINESS OR INDUSTRY Parking | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS 1635 N. Broadway | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Curtis Dickerson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Lee Kesler | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. Korean Conf. 220 20 4589 | | 17. INFORMANT ADDRESS Rosa Dickerson 1635 N. Broadway | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 cardiopulmonary arrest 2° metastatic squamous ca of lung DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from JULY 15, 1982, to JULY 21, 1982, that (X) (we) lost saw the deceased alive on JULY 21, 1982, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) (did X) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE X Gary Miller | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY MILLER | | | | 22e. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-24-82 | 23c. NAME OF CEMETERY OR CREMATORY Arbutus | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO Md. | | | |
| 24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS | | | | ADDRESS 1701 LAURENS ST. | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|------------------------------|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 5 2 1 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | |
| Jason S Diegel | | | | | 07/12/82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| M | | W | | 5 / 26 / 81 | | 1 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | John Hopkins Hospital | | | NONE | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | |
| MD | | | | | BALTIMORE | | 3807 ADY RD | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | |
| JOHN M. DIEGEL | | | | | CATHERINE HALL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| NO | | | | | NONE | | PARENTS ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | |
| 7483 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) TRACHEOTOMY, PLEURAL-ROBIN, CLEFT PALATE, RENAL FAILURE | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) TRACHEOTOMY, PLEURAL-ROBIN, CLEFT PALATE, RENAL FAILURE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the undersigned) attended the deceased from July 1981 to July 1982, that (I) (we) lost saw the deceased alive on 7.12.1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| [Signature] | | | | | | | | 7.12.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| WETZEL | | | | | JOHN HOPKINS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| BURIAL | | | 7/14/82 | | HOLLY HILL | | BALTO. MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | |
| J.G. CONNELLY 300 MACE | | | | | JUL 20 1982 Francis Van Wathen | | | | |

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 1. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17522 | | | | | |
|--|--|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Susan A Dillow | | | | | | | | | | MONTH DAY YEAR 7 10 1982 | | M P.M. | | | |
| 3 SEX F | | 4 RACE W | | 5. DATE OF BIRTH (MONTH DAY YEAR) 12/30/51 | | 6 AGE (IN YEARS) (LAST BIRTHDAY) 30 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 7 10 1982 | | 2d. HOUR 2:00 P.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN MIDDLE RIVER | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 21 SHON CT | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHAS. A. SWIFT | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSEMARY GROGAN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNK | | | | 16b. SOCIAL SECURITY NO. 212 585296 | | 17. INFORMANT ADDRESS CHAS. A. SWIFT 2505 FORKWAY | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:25 7 10 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by auto | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Road | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Langley & Middle River Rds. Middle River, Balto. Co., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-11-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME J. G. CONNELLY | | | | | | ADDRESS 300 MACE | | | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | | | 25b. REGISTRAR'S SIGNATURE James J. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FRANCIS L. DIMLER | | | | | | 2a. DATE OF DEATH MONTH 7 DAY 11 YEAR 1982 | | 2b. HOUR 11:32 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 3 DAY 19 YEAR 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Arbutus | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4728 Aldgate Green 21227 | |
| 14. FATHER'S NAME FIRST Frederick MIDDLE Dimler LAST Dimler | | | | 15. MOTHER'S MAIDEN NAME FIRST Agnes MIDDLE Stencel LAST Stencel | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216-05-8975 | | 17. INFORMANT Mike N. Dimler 4728 Aldgate Green 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Mass in pancreas | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 7/9 , 19 82 , to 7/11 , 19 82 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 7/11 , 19 82 , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE L. Penberthy | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. Penberthy | | | | 22e. ADDRESS Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. ADDRESS 21229 4107 Wilkens Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 REGISTRAR'S SIGNATURE Thane J. Smith | | | | | |

MEDICAL CERTIFICATION

[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]

RECEIVED
JUL 14 1961



JUL 14 1961

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 7 5 2 4 | | | | | |
|--|--|-------------------------|--|--|--|---|--|--|--|--|--|---|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN (JOHNNIE) N. DIXON | | | | | | | | | | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-2-82 | | 2b. HOUR 19 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 5 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 59 YRS. | | 7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-2-82 | | 2d. HOUR 3:39P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2117 Walbrook Avenue | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David S. Dixon | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Montague | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. 230-14-5740 | | 17. INFORMANT ADDRESS Willie Tate 724 New Pittsburg Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Skull fracture and brain contusions | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/1/ 1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject fell | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2104 Ridgehill Ave. Baltimore Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above. (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | MEDICAL EXAMINER | | | | DATE SIGNED 7-3-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE Shane Jan. [Signature] | | | | | |

ORIGINAL FILED

WV 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial/transit permit. These permits are carbon copies. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified as required by law.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 2 5

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) VICTOR P. DODA, SR. | | 2a. DATE OF DEATH MONTH DAY YEAR 7/21/82 | | 2b. HOUR 11:53 PM | |
| 3. SEX M | 4. RACE W. | 5. DATE OF BIRTH MONTH DAY YEAR 11 11 29 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Funeral Director | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Baltimore City | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Doda | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kuusk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF NOT, GIVE WAR OR DATES) Korean 213-28-9230 | | 17. INFORMANT ADDRESS Shuley Doda 1432 E. Fort Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>82</u> , to <u>7/21</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Mary Carroll MD | | DEGREE | | 22c. DATE SIGNED 7/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY CARROLL | | 22e. ADDRESS MERCY HOSPITAL, BALTO. MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem. Glen Burnie, Md. | |
| 24. FUNERAL DIRECTOR NAME Charles L. Stevens | | ADDRESS 1501 E. Fort Ave | | 25a. DATE REC'D. BY REGISTRAR 2.3.1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Frances Van Watten | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1- STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 7 5 2 6 REG. NO. | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | John J. Dodge Sr. | | 2b. DATE OF DEATH MONTH DAY YEAR | |
| John Joseph Dodge Sr. | | | | 7 20 82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| Male | | Cauc. | | 09 26 11 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 70 YRS. | | U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | South Baltimore General Hosp. | | Traffic Mng. | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| Food | | 3902 Eth. St. | | (21225) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATES) | |
| Herbert Dodge | | Catherine Downey | | Yes WWII | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4414 Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) probable myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) hypotension | |
| 217-01-7378 | | Helen M. Dodge (same as 13e) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/20/82 7/19/82 7/19/82 | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ventricular tachycardia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| 7/19/82 | | Abdominal Aneurysm | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 7/18/82 to 7/20/82, that (2) I (we) last saw the deceased alive on 7/20/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) was (were) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| Lawrence R. Bell III | | 7/20/82 | | Lawrence R. Bell III | |
| 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | |
| 3001 S. Hanover St. Baltimore, Md. | | JUL 23 1982 | | Anne J. [Signature] | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/24/82 | | Loudon Park Cemetery | |
| 23d. LOCATION | | 23e. NAME OF CEMETERY OR CREMATORY | | 23f. LOCATION | |
| Baltimore | | Baltimore | | Baltimore | |
| 24. FUNERAL DIRECTOR NAME | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| George J. Gonce F.H. 4001 Ritchie Hwy. | | JUL 23 1982 | | Anne J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 5 2 7 REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John J. Dohony, Sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/14/82 | | | | | 2b. HOUR 7:14 AM | |
| 3. SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 4/25/06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Riderwood, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3422 Cardenas Avenue #21213 | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 13 Policeman | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | 13b. COUNTY - | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3422 Cardenas Avenue | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Nicholas Dohony | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecilia (Nee Creaghan) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 212-03-9699 | | 17. INFORMANT ADDRESS Catherine Dohony, 3422 Cardenas Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Cancer of left lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>mild hypertension</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/1/82</u> to <u>7/14/82</u> , that (I) (we) lost saw the deceased alive on <u>6/1/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Nguyen</u> DEGREE | | | | | 22c. DATE SIGNED 7/15/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Nguyen | | | | | 22e. ADDRESS 6631 Belair Rd. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 7/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | |
| 24. FUNERAL HOME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213 | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE Francis, Jean Nathan | | |

SEP 18 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1- FOR STATE REGISTRAR | | Edith DOLL | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 7 5 2 8 | | REG. NO. | |
|--|--|--|--|--|--|---|--|-----------------------------|--|-----------------------------|--|
| 2. DECEASED NAME (TYPE OR PRINT) | | EDITH | | DOLL | | 2a. DATE OF DEATH | | 7 7 82 | | 2b. HOUR 4:04 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 DAY 8 YEAR 32 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 49 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPS. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife & Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Kent 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RFD Bx 721 | | | | | | | |
| 14. FATHER'S NAME FIRST Marion M. MIDDLE Ireland LAST | | 15. MOTHER'S MAIDEN NAME FIRST Nellie Jacobs MIDDLE LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 420 26 1669 | | 17. INFORMANT Carl Doll | | ADDRESS RFD Chestertown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASTROCYTOMA (Temporal lobe) Grade III | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 6, 19 82, to July 7, 19 82, that (I) (we) lost saw the deceased alive on July 7, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Daniel M. Perlman MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL M. PERLMAN | | 22e. ADDRESS BALTIMORE CITY HOSPITALS, BALTO. MD 21224 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery | | 23d. LOCATION CITY OR TOWN County State Chestertown, Md. | | | | | |
| 24. FUNERAL DIRECTOR J. Willis Wells | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan. Nathan | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|--|---|--|-----------------------------------|--|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. 7 2 1 7 5 2 9 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| MARIE DOMEIKA | | | | | 07 14 82 P M | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| FEMALE | | WHITE | | 10 18 1885 | | 96 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| GERMANY | | GERMANY | | | | BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | | 1324 GLYNDON AVENUE, 21223 | | | | HOMEMAKER | | --- | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| MARYLAND | | | | | --- | | BALTIMORE | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| JOHN MOSSACK | | | | | JUGIA NALES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | 213-54-1752 | | HELEN DOMEIKA 1324 GLYNDON AVENUE, 21223 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> (b) <u>plasma cell dyscrasia</u> (c) <u>plasma cell dyscrasia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>plasma cell dyscrasia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>plasma cell dyscrasia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/82 (21 mo) | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE 21d. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 22b. SIGNATURE DEGREE 22c. DATE SIGNED 22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY COUNTY STATE 24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REG. BY REGISTRAR | | | | | | | | | | |
| KATHY ROBIE-SUH, M.D. UNIVERSITY OF MARYLAND HOSPITAL | | | | | | | | | | |
| BURIAL 07-17-82 LOUDON PARK BALTIMORE CITY MARYLAND | | | | | | | | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. JUL 16 1982 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|---|------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8-2 1 7 5 3 0 CERTIFICATE OF DEATH | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| WILLIAM H. DORSEY, SR. | | | | | MONTH DAY YEAR HOUR 7 31 82 6:45AM | | | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | Mar. 21, 1902 | | 80 | | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore City MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | | | Real Estate | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| 14. FIRST MIDDLE LAST William H. Dorsey | | | | | 15. FIRST MIDDLE LAST Rosalie Hazlett | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | | | 217 03 6262 | | Mrs. Rachael S. Dorsey, Same | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>probable CVA or metabolic abnormality</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>renal failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>prob. prostatic CA</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>arteriosclerotic cardiovascular (if cerebrovascular) dz; sp TURP</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 7/30/82 | | obstructive uropathy; biopsy | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> N/A | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| N/A | | N/A 19 | | N/A | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | | |
| N/A | | N/A | | N/A | | N/A | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>82</u> , to <u>7/31</u> , 19 <u>82</u> , that (we) last saw the deceased alive on <u>7/31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (we) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | 22c. DATE SIGNED | |
| <u>D. Weinreich MD</u> | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 7/31/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| DEBORAH WEINREICH | | | | | UNION MEMORIAL HOSP. Baltimore, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 8/3/82 | | St. Anne's Cemetery | | Annapolis, MD | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | AUG - 2 1982 | | <u>[Signature]</u> | | |

MEDICAL CERTIFICATION

29

320

35

44



1307 BP

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) William G. Doss | | | 7a. DATE OF DEATH MONTH DAY YEAR 7/7/82 | | 2b. HOUR 11:22 PM |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 6 20 27 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City - MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DukeLand N.H. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN BALTO. | 13c. STREET ADDRESS 2215 Mont. Cello Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Doss | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Doss | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. 226-28-7591 | | 17. INFORMANT ADDRESS DukeLand 1501 N. DukeLand St | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Pulmonary Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 1629 | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from 7/5/82 19 82 , to 7/7 19 82 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on 7/7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Darrell M. Gray, M.D. DEGREE | | | | 22c. DATE SIGNED 7/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Darrell M. Gray, M.D. | | | | 22e. ADDRESS 1501 N. DukeLand St. Balto MD 21216 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/12/82 | 23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md. |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | | |

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) John F. Dowell | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 82 | | 2b. HOUR 1055 AM |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 6 14 28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan | | 12a. USUAL OCCUPATION Superintendent | | 12b. KIND OF BUSINESS OR INDUSTRY Grumman Aerospace |
| 13a. STATE Maryland | | | 13b. CITY OR TOWN Dundalk | 13c. STREET ADDRESS 7472 Rabon Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Dowell | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Agnes Fahey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea | | 17. INFORMANT Mary J. Dowell | |
| | | | ADDRESS 7472 Rabon Avenue Balto., MD. 21222 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

1539 IMMEDIATE CAUSE (a) **Cordis - pulmonary arrest**
DUE TO, OR AS A CONSEQUENCE OF
(b) **Concussion of the cerebrum**
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION 7/14/82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 7/14/82 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from 7/14/82 19 82 to 7/14 19 82 , that (1) (we) lost saw the deceased alive on 7/14 19 82 , and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death. | | | |
| 22b. SIGNATURE M.O. Annous | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mouhammad ANNIOUS | | 22e. ADDRESS Good Samaritan Hospital | |

| | | | |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/17/1982 | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 15 1982 Frances Van Natten | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John F. Brown
Wife 2 14 58

BALTIMORE

James David Agnew

George Washington
Washington

George Washington
Washington

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Daisy

B.

Downs

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

7

4

82

7:30

A.M.

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

9

12

1899

6. AGE (IN YEARS LAST BIRTHDAY)

82

YRS

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Frederick Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

Balto., Md. 21223

2120 W. Baltimore Street

14. FATHER'S NAME

Bernard

MIDDLE

LAST

Jones

15. MOTHER'S MAIDEN NAME

Clara

MIDDLE

LAST

Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215-14-7769

17. INFORMANT

Mr. Hugh Sharpe

ADDRESS

Maryland 21223

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

5850

IMMEDIATE CAUSE (a)

Cardiopulm. Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

Renal Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-26-82, 1982, to 7-4-82, 1982, that (I) (we) lost the deceased alive on 6-25-82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Larry S. Penny

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Larry S. Penny

22e. ADDRESS

2600 Liberty Highway

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7/8/82

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Baltimore City, Maryland

24. FUNERAL DIRECTOR NAME

Baltimore

ADDRESS

Maryland 21216

25a. DATE REC'D. BY REGISTRAR

JUL 8 1982

REGISTRAR'S SIGNATURE

James Van Natta

HERBERT E. NATHAN Funeral Home 5035 W. NORTH AVE.

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RECEIVED
JUN 11 1964
U.S. AIR FORCE

RECEIVED
JUN 11 1964
U.S. AIR FORCE

RECEIVED
JUN 11 1964
U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 5 3 4 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William H Dreyer | | | | 2a. DATE OF DEATH MONTH 7 DAY 4 YEAR 82 2b. HOUR 4:00 A.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 1 DAY 9 YEAR 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO CITY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY Insurance | |
| 13a. STATE MD | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Fritz MIDDLE LAST Dreyer | | | | 15. MOTHER'S MAIDEN NAME FIRST Elise MIDDLE LAST Krundiak | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212075570 | | 17. INFORMANT ADDRESS NCGH - INPATIENT ADMISSIONS FORM | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4029 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 9 YEARS 9 YEARS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CVA, ORGANIC BRAIN SYNDROME, CHOLELITHIASIS | | | | | | | |
| 19a. DATE OF OPERATION 5/7/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED GALL STONES | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH N/A YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> WHILE AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | | 21f. LOCATION STREET N/A CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/8 , 19 82 , to 7/4 , 19 82 , that (I) (we) lost saw the deceased alive on 7/4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Chatchaval Vuthiganon | | | | DEGREE | | 22c. DATE SIGNED 7/4/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHATCHAVAN VUTHIGANON | | | | 22e. ADDRESS NORTH CHARLES GENERAL HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-7-82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home ADDRESS 6500 York Rd 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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THE UNIVERSITY OF CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMM - 16 50M 1/B1
(VRA 15, 4)

item 6 #G569 7/26/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| VEORAH | | DRIVER | | JULY 7, 1982 | | 9:35 p.m. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | BLACK | 11 20 1913 | | 70 68 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| RED Springs N.C. | USA | | | BALTO CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | CHURCH HOME HOSPITAL | | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | | |
| 13a. Md. BALTO HO. | | BALTO | | 227 Chestnut St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Cleveland | | Graham | | Victoria | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | UNK. | | Thomas Driver 227 Chestnut St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA RIGHT LUNG WITH METASTASIS 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-16, 19 82, to 7-7, 19 82, that (I) (we) lost saw the deceased alive on 7-7, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| SARVA GIRDHAR | | CHURCH HOSPITAL CORPORATION | | 100 North Broadway Baltimore, Maryland 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/12/82 | | King Memorial Park | | BALTO MD. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE RECORDED BY REGISTRAR SIGNATURE | | | |
| James A. Morton | | 1701 Laurens | | JUL 13 1982 Francis J. Matthews | | | |



Handwritten text, possibly a date or reference number, located in the upper middle section of the page.

Handwritten text, possibly a name or title, located in the middle section of the page.

Handwritten text, possibly a description or address, located in the lower middle section of the page.

Handwritten text, possibly a signature or note, located in the bottom middle section of the page.

Handwritten text, possibly a date or reference number, located in the bottom left section of the page.

Handwritten text, possibly a name or title, located in the bottom right section of the page.

Handwritten text, possibly a description or address, located in the bottom right section of the page.

Handwritten text, possibly a signature or note, located in the bottom right section of the page.

Handwritten text, possibly a date or reference number, located in the bottom right section of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 3 6

1- STATE REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) THOMAS P. DRURY | | | 2a. DATE OF DEATH MONTH 7 DAY 5 YEAR 82 | | | 2b. HOUR 740 PM | | | |
| 3 SEX Male | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH 3 DAY 21 YEAR 41 | | 6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS | | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. | |
| 7a. BIRTHPLACE (COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD. | | | |
| 10 CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALT GEN HOSP | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CITY BULK | | 12b. KIND OF BUSINESS OR INDUSTRY HEAVY LIFTING | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1469 WOODALL ST | | | | |
| 14 FATHER'S NAME FIRST TITOMNS MIDDLE P LAST DRURY | | | | 15 MOTHER'S MAIDEN NAME FIRST ELIZABETH MIDDLE H LAST TYSON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 6 FEB 68-18 APR 82 218-86-9946 | | 17 INFORMANT JAMES BURG ADDRESS 1469 WOODALL ST | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARDIAC ARRHYTHMIA, ARROXIA WHILE UNDER CARD. PULM ARREST | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/5 , 19 82 , to 7/5 , 19 82 , that (I) (we) last saw the deceased alive on 7/5 , 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. McCarthy | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/5/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MCCARTHY | | | | 22e. ADDRESS 3001 S. HANOVER ST. BALT. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE | | | |
| 24 FUNERAL DIRECTOR NAME CHARLES L. STEVENS ADDRESS Federal Home, Inc. 1501 E. FOOT AVE. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called by the funeral director.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. 7 2 1 7 5 3 7 | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR SARA | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARA B. DUBOIS | | 2a. DATE OF DEATH MONTH DAY YEAR 07-08-82 7 P M | |
| 3. SEX FEMALE | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 02 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 10. CITY OR TOWN OF DEATH BALTO. MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST MEYER | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHAEL HARRIS | 12b. KIND OF BUSINESS OR INDUSTRY REGISTER OF WILL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | 16b. SOCIAL SECURITY NO. 217-34-6743 | 17. INFORMANT MR. A. HAROLD DUBOIS 8203 MAXINE CIR. #21208 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>EXSANGUINATION</u> 5192 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MEDIASTINITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>AORTIC VALVE DISEASE; AORTIC VALVE REPLACEMENT</u> | | | |
| 19a. DATE OF OPERATION 06-23-82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>06-21-82</u> , 19 <u>82</u> , to <u>07-08</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>07-08</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>Stephen Lincoln</i> | 22c. DATE SIGNED 07-08-82 | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN LINCOLN M.D. | |
| 22e. ADDRESS 22 GREENE ST., BALTO. MD. | 22f. DATE REC'D. BY REGISTRAR JUL 14 1982 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JULY 11, 1982 | 23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17538 | |
|--|--|-------------------------|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lavern Duffy | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 25 19 82 | | 2b. HOUR M 4:15 | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 2 60 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 21 | | IF UNDER 1 YR. MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN. 0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Woods/3101 Swan Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 570 Baker Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Marvin Duffy | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Meade | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Allustus Brown 1721 Prestman St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 9630 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.mest: 7/25 19 82 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found strangled | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods/Druid Hill Pk | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3101 Swan Drive Near Mtn Rd, Baltimore, MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Virginia L. Dolan</i> | | | | M.D. Assistant | | | | DATE SIGNED 7/26/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7-30-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>James Santhron</i> | | | | | |

100-111111

100-111111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 5 | 3 | 9 |
|---|--|--|---|--|--|--|--|--|---|--|---|-------------------------------------|---|-----------------------------|---|---|
| 1. FOR STATE REGISTRAR | | | | | | REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Willie B. Dundee | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 22, 1982 | | | | | | 2b. HOUR M | | | | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH DAY YEAR 2 22 17 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3353 W. Belvedere Avenue | | | | | | | | | | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MD | | | | | | 12b. COUNTY Baltimore | | 12c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12d. STREET ADDRESS 3353 W. Belvedere Avenue | | | | | | |
| 13. FATHER'S NAME FIRST MIDDLE LAST Purlie Dundee | | | | | | 14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tildie Dundee | | | | | | | | | | |
| 15a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | 15b. SOCIAL SECURITY NO. 249-10-7306 | | 15c. INFORMANT ADDRESS Danie Dundee 3353 W. Belvedere Ave. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the (R) lung with involvement of chest wall DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 months | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Arteriosclerotic occlusive disease, carotid arteries | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 01/13/81 01/27/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right upper lobectomy, chest wall resection Bopsy of chest wall | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from December, 19 80 to 05/06 19 82 , that (1) (we) lost saw the deceased alive on 05/06 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE John R. Hankins, | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 07/23/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Hankins, MD | | | | 22e. ADDRESS 22 South Greene St. Baltimore, MD 21201 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE RECD. BY REGISTRAR, REG. NO. SIGNATURE JUL 26 1982 James Jan Nathan | | | | | | |

20

RECEIVED

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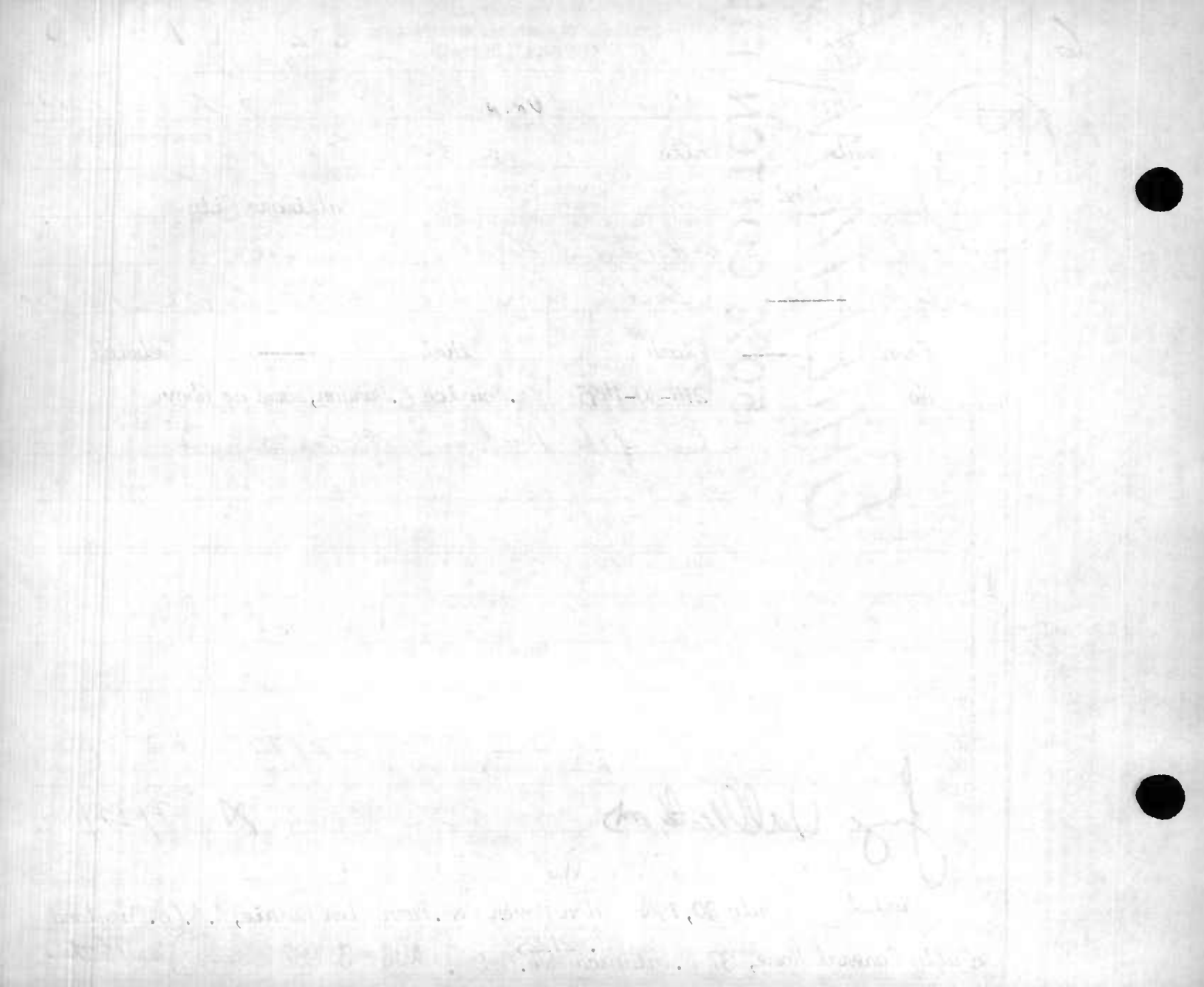
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 5h | | 8 2 | | 1 7 5 4 0 | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| FIRST MIDDLE LAST Shirley Marie Dugan | | | | MONTH DAY YEAR 7 27 82 | | | | HOUR MIN. 2:25 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Female | | Cao White | | MONTH DAY YEAR 6 15 34 | | 58 YRS | | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| U.S.A. Maryland | | U.S.A. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balt. | | S. Balt. General Hosp. | | | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Balt. Md. | | Balt. | | Balt. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4105 Brooklyn Ave. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST Frank ----- Clark | | | | FIRST MIDDLE LAST Ethel ----- Gelwick | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | 216-30-1495 | | Mr. Maurice E. Dugan, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Ca. of the Rectum & Metastasis | | | | | | | | | |
| 1541 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/15/82 to 7/27/82, that (we) lost saw the deceased alive on 7/27/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Jorge Vallecillo, MD | | | | | | | | 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Jorge Vallecillo | | SBGH | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | July 30, 1982 | | Glen Haven Mem. Park | | Glen Burnie, A.A. Co. Maryland | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS McCurly Funeral Home, 237 E. Patapsco Ave. Balto. Md. 21225 | | AUG - 3 1982 | | | | Francis Jan Nathan | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DATE OF DEATH | | 3. MONTH | | 4. DAY | | 5. YEAR | | 6. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE OF DEATH | | 3. MONTH | |
| Nona | | Durham | | July | | 18 | | 82 | | M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 74 HRS | |
| Female | | Black | | 5 16 13 | | 69 | | MONTHS | | DAYS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 11. KIND OF BUSINESS OR INDUSTRY | |
| North Carolina | | U.S.A. | | | | Balto. City | | retired | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | |
| Balto. City | | Bon Secours Hosp. | | | | | | md. | | Balto. City | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. STREET ADDRESS | |
| md. | | | | Balto. City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1410 W. Saratoga St. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| John | | Minnie | | | | 215-12-3000 | | CHART | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. DUE TO, OR AS A CONSEQUENCE OF | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | CARDIO PULMONARY ARREST. | | 4/100 | | MYOCARDIAL INFARCTION | | Few MINUTES | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | HYPER TENSION. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | DIABETES | | MELLITUS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| and | | me. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. NA 19 | | N.A. | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| NA | | NA | | NA | | NA | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-10-1982, to 7-13-1982, that (I) (we) lost the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| | | S. JULKA | | MD | | 7-19-82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| S. JULKA | | Bon Secours Hospital | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| BURIAL | | 7-23-82 | | CROWNSVILLE VET. | | CROWNSVILLE | | MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | 25. DATE REC'D. BY REGISTRAR | | 25a. REGISTRAR'S SIGNATURE | | | | | | | |
| E. L. PHILLIPS | | 1721 N. MONROE ST. | | JUL 20 1982 | | Frances Sam Nathan | | | | | |

MEDICAL CERTIFICATION



Don't know

Book 2

U.S.A.

East City

Hardcore

Hold

2014-2015

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 5 4 2 | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) DIANE Lee EATON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 17 82 | | 2b. HOUR 4:55 P | | M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 28 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS. | | IF UNDER 1 YEAR MONTHS DAYS 00 00 | | IF UNDER 24 HR. HOURS MIN. 00 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) L.I., N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna. 13b. COUNTY ✓ | | | | | | 13c. CITY OR TOWN Norristown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2977 Sheffield Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Raymond Werhane | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marian Payne | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Alan E. Eaton | | ADDRESS Same | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2051 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) FUNGAL SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC MYELOGENOUS LEUKEMIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/19 19 82 , to 7/17 19 82 , that (I) (we) last saw the deceased alive on 7/17/82 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dolph Druckman MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 7/17/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOLPH DRUCKMAN MD, MPH | | | | | | 22e. ADDRESS BALTIMORE CITY HOSPITALS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial | | 23b. DATE 7-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Plymouth Meeting Pa. | | | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co., Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY SISK EDEL | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 03, 1982 | | 2b. HOUR 03:46AM |
| 3. SEX Female | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR Aug 19 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice-Princip. Teaching | | |
| 13a. STATE MD. | | 13b. CITY OR TOWN Balto. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 6 Linden Ave. 21204 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert Sisk | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Gore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 215-14-4084 | | 17. INFORMANT ADDRESS Charles H.B. Edel (same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 18a. IMMEDIATE CAUSE (a) 4100 Ventricular arrhythmia/cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) heart muscle damaged by M.I. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/82 , 19 82 , to 7/3 , 19 82 , that (I) (we) lost saw the deceased alive on 7/3 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Andrei B. Bough | | DEGREE | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrei Bough MD | | 22e. ADDRESS Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | 23b. DATE July 5, 82 | 23c. NAME OF CEMETERY OR CREMATORY GreenMount | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons | | ADDRESS 4905 York Rd Balto. Md. 21212 | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | 25b. REGISTRAR'S SIGNATURE James J. [Signature] |

Albert
 Sick
 Marie
 Gore
 M. B.
 Balbo.
 Townson
 6 Linden Ave., 2122
 Vice-President, Teachers
 Maryland
 U.S.A.
 1919
 62

212-11-1091 Charles H.B. Edel (same)

[Faint, illegible handwriting]



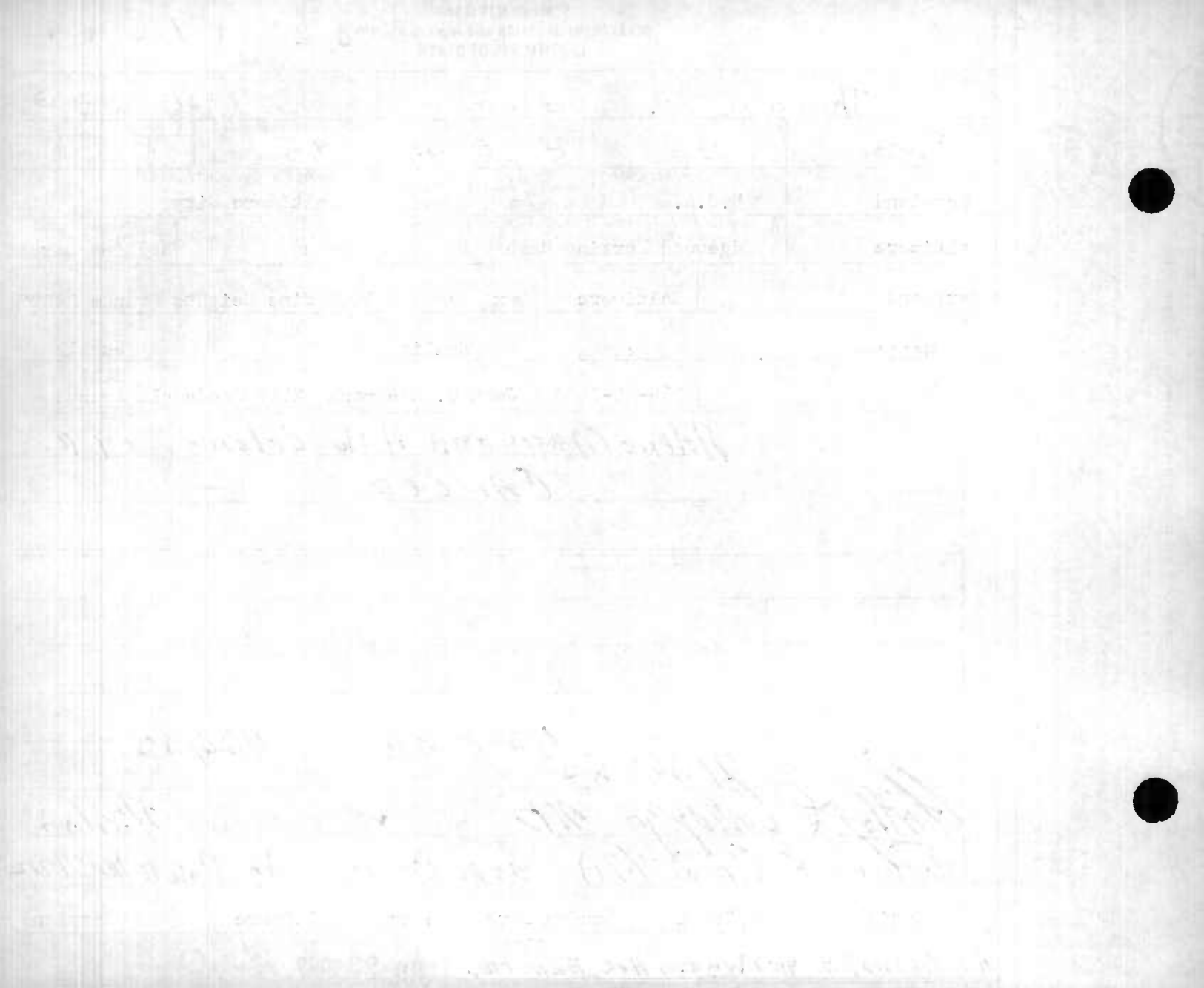
Henry W. Tenkingsons
 Baltimore
 1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 5 4 4 | | | |
|--|--|------------------------------|--|---|--|------------------------------------|--|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| THERESA | | | | O. EDELMANN | | | | 7-26-82 | | | | 5 55 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR 5 26 97 | | | | 85 | | MONTHS DAYS | | HOURS MIN | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S.A. | | | | | | Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | | Edgewood Nursing Home | | | | Sales | | | | Hollins Market | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | | | | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1040 Pine Heights Avenue 21229 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | |
| William A. Mielke | | | | Emelia Schalk | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | | | |
| NO | | | | 218-42-3456 | | John G. Edelmanna | | | | 21214 2707 Woodsdale Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA of the COLON -</u> <u>1539</u> DUE TO, OR AS A CONSEQUENCE OF <u>CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>-</u> (c) <u>-</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 R.</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/24/82</u> to <u>7/26/82</u> , that (I) (we) lost <u>4/29/82</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | DEGREE | | 22c. DATE SIGNED | |
| Anthony F. Carozza | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| Anthony F. Carozza | | | | 6000 BELLEHA AVE BALTIMORE 21212 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 7/29/82 | | Loudon Park Cemetery | | | | Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | |
| Hubbard Funeral Home, Inc. | | | | 4107 Wilkens Ave. | | | | 21229 | | | | JUL 28 1982 | |



Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

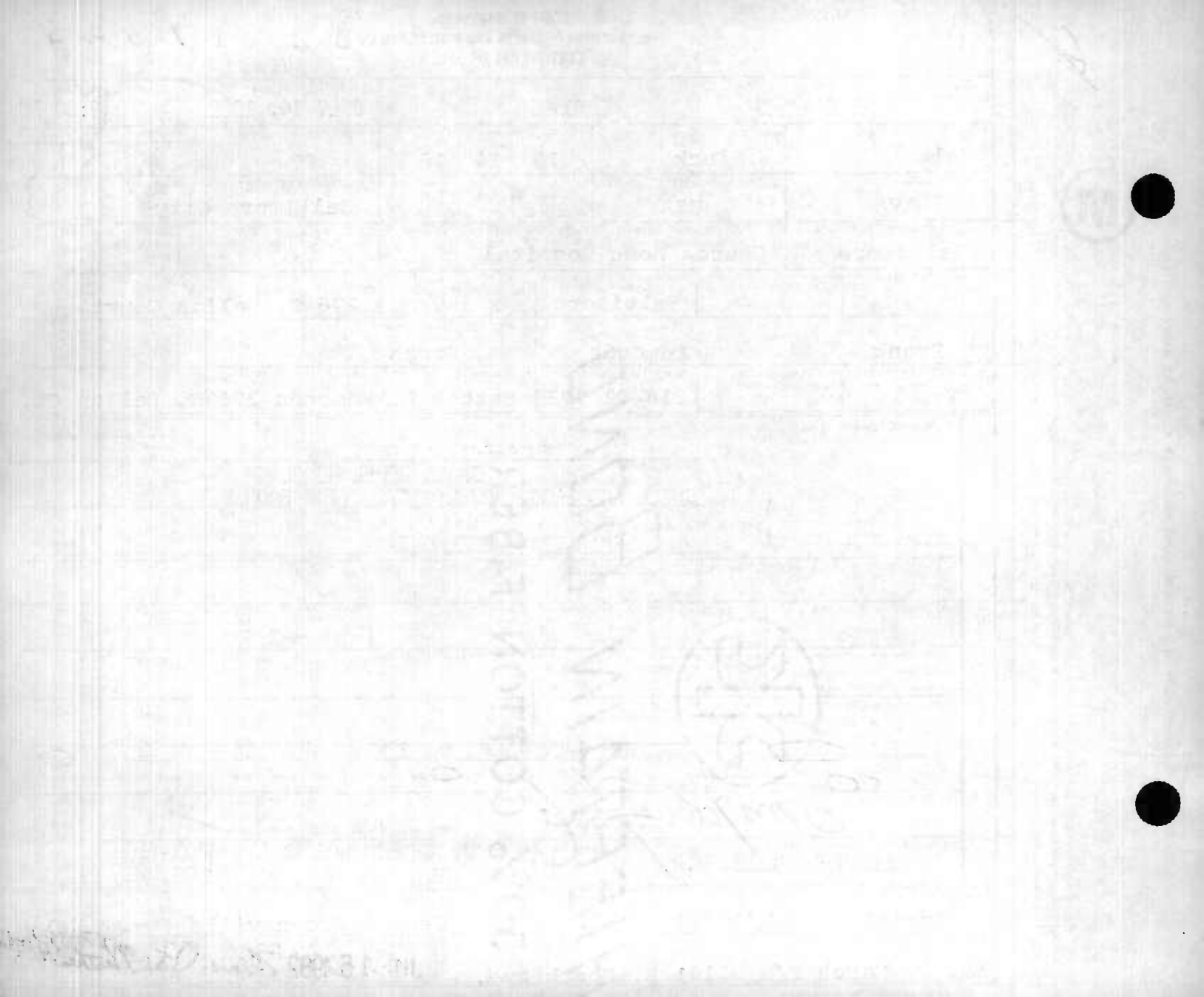
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES EDMONDS | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1982 | | 2b. HOUR 8:30 AM | | | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 14 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 276 S. Dallas Court | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Edmonds | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-7933 | | 17. INFORMANT ADDRESS Hattie L. Edmonds 276 S. Dallas Ct. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS 1529 } DUE TO, OR AS A CONSEQUENCE OF SMALL BOWEL NEOPLASM (b) SMALL AND LARGE BOWEL OBSTRUCTION FROM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASPIRATION PNEUMONIA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 9, 19 82, to JULY 14, 19 82, that (I) (we) last saw the deceased alive on JULY 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Prasad Sompalli | | | DEGREE | | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PRASAD SOMPALLI, M.D. | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY, BALTIMORE, MD 21231 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natta | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 5 4 6 | | | | |
|---|--|---|--|--|----------------------|---|--|-----------------------|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | | MONTH DAY YEAR | | | | |
| ELMON K EDMONDS | | | | | 7 14 82 | | | | | 4 15 A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | | | |
| Male M | | White | | MONTH DAY YEAR 10 28 22 | | 59 YRS. | | MONTHS DAYS | | HOURS MIN. | | | | |
| 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | |
| Country: Virginia | | U.S. | | NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| BALTIMORE CITY | | UNIV. OF MARYLAND HOSP. | | Contractor | | Construction | | | | | | | | |
| 13a. USUAL RESIDENCE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | | |
| MARYLAND | | Keymar | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 12613 GOODINTENT ROAD | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| FIRST MIDDLE LAST FLOYD K EDMONDS | | FIRST MIDDLE LAST Elizabeth Maudy Wornell | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | |
| Yes (YES, NO OR UNKNOWN) WW II | | 224-20-2395 | | Mary Hiner | | Keymar, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| 4920 IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | | | | | | | < 1 HOUR | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | YEARS | | | | |
| (b) EMPHYSEMA | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| OAT CELL CARCINOMA OF LUNG | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | | | | |
| OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | P.M. 19 | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | |
| AT WORK <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 74 to JULY 19 82, that (I) (we) last saw the deceased alive on July 14 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | | |
| M. So, MD | | | | 7/14/82 | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | | |
| M. So | | 22 S. GREENE ST. BALTIMORE, MD. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | |
| Burial | | 7/18/82 | | Resthaven Mem. Gar. | | CITY OR TOWN Frederick, MD. | | COUNTY Frederick, MD. | | STATE | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| NAME 1621 Opossumtown Pk. | | JUL 21 1982 | | Name & Signature | | | | | | | | | | |
| G. Douglas Stauffer Frederick, Md. | | | | | | | | | | | | | | |

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• O'Connell's Book Store •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JEAN F EDMONDS | | | 2a. DATE OF DEATH MONTH 7 DAY 17 YEAR 82 | | 2b. HOUR 11:04 AM |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH 06 DAY 01 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST RICHARD MIDDLE WHITE LAST WHITE | | | 15. MOTHER'S MAIDEN NAME FIRST GEORGIANNA MIDDLE CALVERT LAST CALVERT | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-2-1255 | 17. INFORMANT Phyllis J. Edmonds ADDRESS 200 Diener Pl | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxia DUE TO, OR AS A CONSEQUENCE OF (c) END STAGE Chronic Obstructive Lung Disease | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minute |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SQUAMOUS CELL CA Lung w/ PROB. BRAIN METASTASES | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/82 , 19 82 , to 7/17 , 19 82 , that (I) (we) last saw the deceased alive on 7/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE M. Dallymore MD | | DEGREE | | 22c. DATE SIGNED 7/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maurice Dallymore MD | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK | |
| 23d. LOCATION CITY OR TOWN Baltimore, H.C. | | STATE Md | | | |
| 24. FUNERAL DIRECTOR Chas. A. Rice FSPA | | ADDRESS 1300 Eutaw Pl | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | |
| 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 17 548 | |
|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST HELEN M. EDMONSTON | | | | MONTH DAY YEAR 7 3 82 | 2b. HOUR 4 P.M. |
| 3. SEX Female | | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR March 29, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | 12b. KIND OF BUSINESS OR INDUSTRY Building & Loan Assoc. |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank W. Mallonee | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Belle Burns | | 13e. STREET ADDRESS 116 W. University Pkwy. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212 34 7046 | | 17. INFORMANT ADDRESS L. Franklin Gerber, Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC OVARIAN Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1830 | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 82 , to 7 3 , 19 82 , that (I) (we) last saw the deceased alive on never , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Richard A. Marasa | | DEGREE M.D. | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. MARASA | | 22e. ADDRESS UNION MEMORIAL 165 P. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | 23e. DATE REC'D BY REGISTRAR JUL 7 1982 | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. | | 24b. ADDRESS 4905 York Road Balto., Md. 21212 | | 25b. REGISTRAR'S SIGNATURE Charles J. Nathan | |



| NAME | RESIDENCE | EDUCATION |
|----------|-----------------------|-----------|
| Frank W. | W. Malone | White |
| Marjorie | U. | White |
| SAUL | UNION REFORM HOSPITAL | White |
| Marjorie | Baltimore | White |
| Frank W. | W. Malone | White |
| SAUL | UNION REFORM HOSPITAL | White |
| Marjorie | Baltimore | White |

CHARLES H. HARRIS, JR.
McGraw-Hill

Charles H. Harris, Jr.
McGraw-Hill
New York, N.Y.
1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 7 2 1 7 5 4 9 REG. NO. | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELVA MAE EDWARDS | | | | | | 2a. DATE OF DEATH MONTH 7 DAY 01 YEAR 82 | | | | 2b. HOUR 4:30 AM | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH 5 DAY 4 YEAR 98 | | 6 AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS YRS. | | IF UNDER 72 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY at Home | | | |
| 13a. STATE Penna. | | 13b. COUNTY Bedford | | 13c. CITY OR TOWN Saxton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1204 Mifflin Street (16678) | | | |
| 14. FATHER'S NAME FIRST John MIDDLE Hammond LAST Hammond | | | | 15. MOTHER'S MAIDEN NAME FIRST Lena MIDDLE Renrick LAST Renrick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. ? | | 16c. PLACE OF DEATH SLACK Funeral Home, Saxton, Penna. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) gangrene of left foot. DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| | | | | | | | | | | 3 months | |
| | | | | | | | | | | 8 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Klebsiella pneumonia; atrial fibrillation episodes; Hypokalemia | | | | | | | | | | | |
| 19a. DATE OF OPERATION 4/26 & 5/14/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of L^t foot. | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4 / 12 / 19 82 to 7 / 1 / 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 7 / 1 / 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Chalaby | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7 / 1 / 82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHALABY | | | | 22e. ADDRESS 900 S. CATON AVE., BALTO. 21229 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Grandview Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Saxton, Bedford, Penna. | | | |
| 24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043 | | | | ADDRESS 21043 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 2 1982 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "CHURCH" and "SOCIETY" are visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17550 | |
|--|--|-------------------------|--|---|---|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Stephen Turner Eggly | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 14 19 82 | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1945 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 36 | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 14 19 82 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5003 LaSalle Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elbert Eggly | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Turner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 139-34-4987 | | | 17. INFORMANT ADDRESS Linda Eggly 5003 LaSalle Ave. Balto. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Thomas D. Smith</i> | | | | TITLE (SPECIFY) Deputy Chief | | | | DATE SIGNED 7/15/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE July 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | | 23d. LOCATION COUNTY Maryland STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR Jul 15 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i> | | | |

January 1967

Main Date Jan. 17, 1967 to

County of Santa Clara, Cal.

San Jose

San Jose

3007 Lastrilla Ave.

San Jose

San Jose

Street

San Jose

San Jose

No.

170-17-007

170-17-007 Linda Kelly 3007 Lastrilla Ave. San Jose, Cal.

July 17, 1967 San Jose

San Jose

San Jose, Cal. San Jose, Cal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 5 5 1 | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST CALVIN N. EICHOLTZ | | | | MONTH DAY YEAR July 7, 1982 | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4 - 3 - 92 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 90 | | 7. IF UNDER 1 YEAR MONTHS DAYS YRS. | | 8. IF UNDER 24 HRS. HOURS MIN. YRS. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2819 KILDAIRE DRIVE | | 14. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MARYLAND | | 15b. COUNTY - | | 15c. CITY OR TOWN BALTIMORE | |
| 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 17. STREET ADDRESS 2819 KILDAIRE DRIVE | | 18. FATHER'S NAME FIRST MIDDLE LAST ANDERSON N. EICHOLTZ | |
| 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BETTY STAINE | | 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 21. SOCIAL SECURITY NO. 215-44-0195 | |
| 22. INFORMANT Mrs. Lillie Belle Eicholtz | | 23. ADDRESS 2819 KILDAIRE DR. | | 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Renal Failure 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Obstructive Uropathy 2 yrs DUE TO, OR AS A CONSEQUENCE OF (c) Chronic UTI 75 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) - | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR - | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) - | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) - | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE - | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/1 - 19/82 , to 7/7/82 , that (I) (we) last saw the deceased alive on 6/30/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Gregory L. Walker | | 22c. DEGREE MD | | 22d. DATE SIGNED 7/8/82 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORY L. WALKER | | 22f. ADDRESS 201 E University Pkwy 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | 23b. DATE July 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Union Cem | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE KEYSVILLE MD. | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE 7/11/82 Frances Van Warden | | | |
| 24. FUNERAL DIRECTOR NAME HARTLEY MILLER | | 24b. ADDRESS 7527 HARFORD RD. | | | |



MEMORANDUM FOR THE SECRETARY OF DEFENSE

DATE: 10-1-77

X

U.S.A.

SECRETARY OF DEFENSE

X

SECRET

SECRET

11

11

X

SECRETARY OF DEFENSE

SECRETARY OF DEFENSE

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE

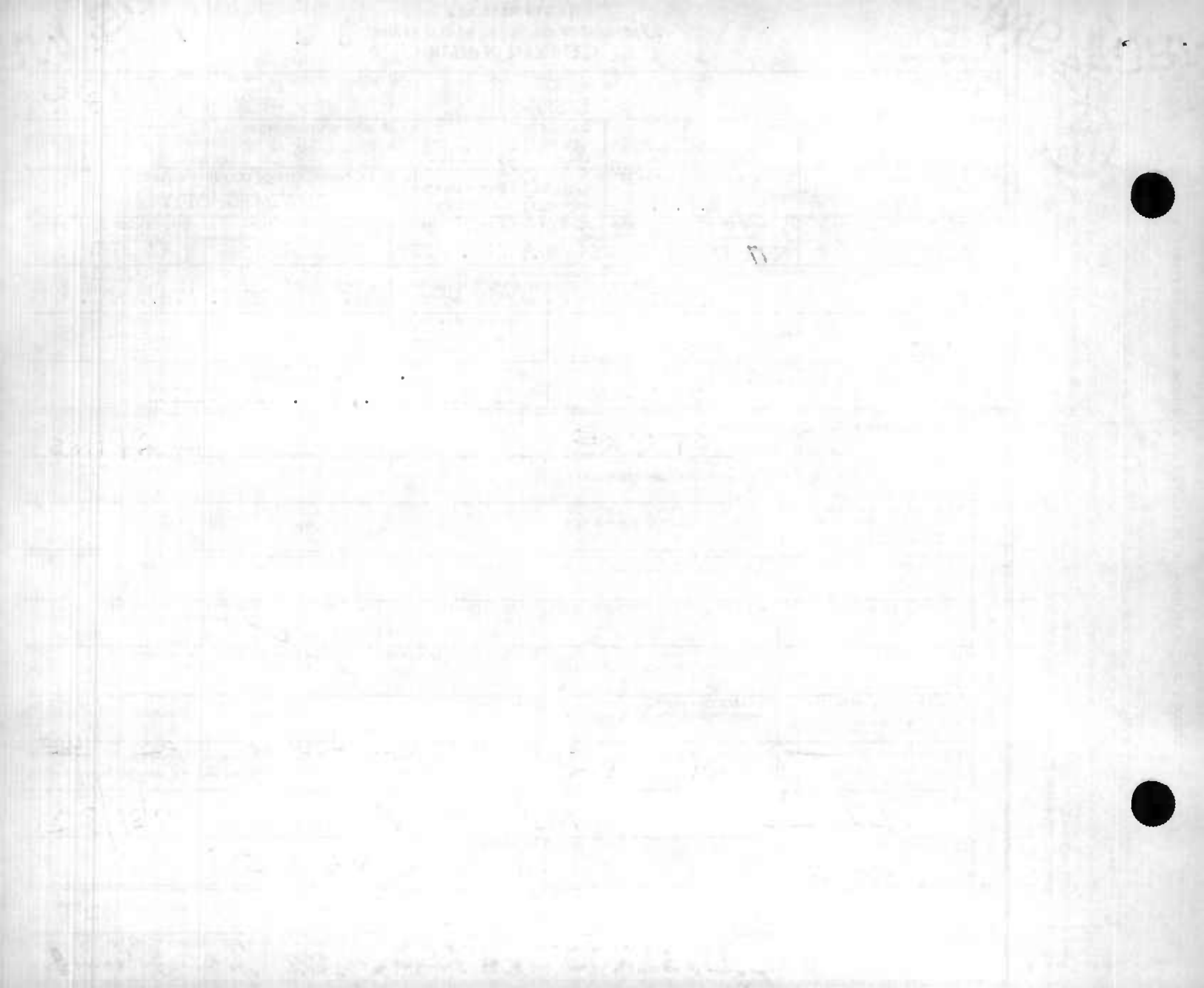
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 5 5 2 | | | | | |
|--|--|--|--|--|-----------------------------------|---|---|---------------------------|---|--|-----------------|--|---------|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH DAY YEAR | | 2b HOUR | | |
| YETTA | | | | | | | EISEN | | JULY 30, 1982 | | | | 335 P M | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | 7 UNDER 1 YEAR | | 7 UNDER 24 HRS | |
| FEMALE | | | CAUCASIAN | | | MAY 12, 1893 | | | 89 YRS. | | | MONTHS DAYS | | HOURS MIN. | |
| 8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 8b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| POLAND | | | U.S.A. | | | | | | BALTIMORE CITY MD. | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | | 6317 PARK HEIGHTS AVE., APT. 403 | | | | | | | | | HOUSEWIFE | | AT HOME | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | #21215 | | | |
| MARYLAND | | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6317 PARK HGTS. AVE., APT. 403 | | | | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | | |
| CHAIM | | | SNYDER | | | FLORENCE | | | UNKNOWN | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | MRS. PAUL FINEMAN | | | | | | |
| NO | | | 219-18-4140 | | | 11 SLADE AVE., APT. 816 | | | #21208 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STROKE</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 24 HRS | | | |
| 4360 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | (b) | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | | | | | | | | | (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | |
| | | | P.M. 19 | | | | | | | | | | | | |
| 21d INJURY OCCURRED | | | 21e PLACE OF INJURY | | | 21f LOCATION | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET | | | CITY OR TOWN | | | COUNTY STATE | | | |
| 22a I certify that (I) (the hospital) attended the deceased from <u>prior to July 29, 1982</u> to <u>July 30, 1982</u> , that (I) (we) first saw the deceased alive on <u>July 29, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c DATE SIGNED | | | | | | |
| <u>[Signature]</u> | | | MD | | | | | | 7/31/82 | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e ADDRESS | | | | | | | | | | | | |
| BRIAN KANTROFF | | | 11 Slade Ave 21208 | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION | | | COUNTY MD STATE | | | | |
| BURIAL | | | 8-1-82 | | BETH TFILOH CONG. | | | BALTIMORE | | | | | | | |
| 24 FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. | | | | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | | | AUG - 5 1982 | | <u>[Signature]</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE MINNIE ELGERT | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/21/82 | | 2b. HOUR 5:15 PM | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 6 2 96 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | 13. STREET ADDRESS 707 Keidel Drive 21228 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown to Records | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown to Records | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 17. SOCIAL SECURITY NO. 214-54-8683 | | 18. INFORMANT Ernest P. Elgert Jr. Balto. 21227 | | 19. ADDRESS 5512 Link Ave. | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & circulatory arrest</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CVA (Cerebrovascular)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>accident</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): (Diabetes) DM, High Blood Pressure, & 1 | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21g. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/17/82</u> 19 <u>82</u> , to <u>7/21</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Purneshottam Mitra | | 22c. DATE SIGNED 7/21/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTTAM MITRA | | |
| 22e. ADDRESS MacNabb Funeral Home Catonsville, MD | | 22f. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 22g. REGISTRAR'S SIGNATURE James J. [Signature] | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Pk. Sykesville Carroll MD | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 23f. REGISTRAR'S SIGNATURE James J. [Signature] | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this page has been signed by the attending physician and completed filled in by the funeral director, page 1 should be detached for use as a burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other reason for death, a medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 7 2 1 7 5 5 4 | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOE (JOSEPH) ELLISON | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 24 1982 | | | | 2b. HOUR 7:27a | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 16 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 969 N. Chester Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Ellison | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Williams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 251-26-4234 | | 17. INFORMANT ADDRESS Louise Coe Ellison 969 N. Chester St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 0417 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NECROTIZING PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) PSEUDOMONAS INFECTION | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 2 WEEKS 2 WEEKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 4, 1982 , to JULY 24, 1982 , that (I) (we) last saw the deceased alive on JULY 24, 1982 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Neil M. Bressler MD | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEIL M. BRESSLER | | | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-29-82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balti more Md. | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Santhron | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|-------------------|--|------------------|--|---------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. DATE OF DEATH | | 7. HOUR | |
| | | Paul G. Ellison | | MALE | | WHITE | | 1-30-08 | | 7/5/82 | | 2:15 PM | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. CITIZEN OF WHAT COUNTRY? | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| West Virginia | | U.S. | | | | Baltimore | | | | | | | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | Baltimore Hospital | | Clergyman | | Cleric | | | | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER FACILITY, GIVE SITE RESIDENCE BEFORE ADMISSION) | | 17. INSIDE CITY LIMITS? | | 18. STREET ADDRESS | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1819 Gough Street | | | | | |
| Md. | | | | Baltimore | | | | | | | | | |
| 19. FATHER'S NAME FIRST MIDDLE LAST | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| Charles - Ellison | | ELVA - MAXWELL | | | | | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 22. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 23. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 236-14-7778 | | Garnet Ellison | | 1819 Gough St. | | | | | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 CVA; multiple several years DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | 25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | 27. cervical spondylitis several years | | | | | | | | | | | |
| 28. DATE OF OPERATION | | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 30. AUTOPSY? | | 31. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 32. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 33. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 34. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | 19 | | | | | | | | | | | |
| 35. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 36. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 37. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 38. I certify that (I) (this hospital) attended the deceased from 11/14/81 to 7/5/82, that (I) (we) last saw the deceased alive on 7-5-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 39. SIGNATURE E. Ellsworth Cook MD | | 40. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 41. DATE SIGNED 7-6-82 | | | | | | | |
| 42. PHYSICIAN'S NAME (TYPE OR PRINT) | | 43. ADDRESS | | | | | | | | | | | |
| E. Ellsworth Cook | | 2431 Md. Ave. Balt 21218 Md | | | | | | | | | | | |
| 44. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 45. DATE | | 46. NAME OF CEMETERY OR CREMATORY | | 47. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | July 9, 1982 | | Gardens of Faith Cem. | | - - Baltimore Co., Md. | | | | | | | |
| 48. FUNERAL DIRECTOR NAME | | 49. ADDRESS | | 50. DATE REC'D. BY REGISTRAR | | 51. REGISTRAR'S SIGNATURE | | | | | | | |
| Lilly & Zeiler Inc. 1901 Eastern Ave. | | | | JUL 9 1982 | | Thom J. [Signature] | | | | | | | |

July 9 - 1902 Eastern Ave.

July 9 - 1902 Eastern Ave. - Baltimore Co., Md.

July 9 - 1902 Eastern Ave.

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July 9 - 1902 Eastern Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 5 5 6 REG. NO. | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Ruth May English | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 17 82 | | | |
| 3. SEX female | | 4. RACE cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 07 04 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City of Baltimore MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S. Balto. Gen. Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PACKER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. CITY OR TOWN BROOKLYN PARK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 650 Sunset Strip | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Louis Harthausen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH REILLY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-70-7113 | | 17. INFORMANT ADDRESS ERNEST E. ENGLISH, SR. 650 SUNSET STRIP | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Wide spread Co. breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) this hospital attended the deceased from July 13 , 19 82 , to July 17 , 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on July 17 , 19 82 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Alan N. Dennis MD | | | | DEGREE MD | | 22c. DATE SIGNED 7/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan N. Dennis | | | | 22e. ADDRESS 3001 S. Hanover St., Balto, MD 21230 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ELKBRIDGE HOWARD MARYLAND | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 21229 4107 WILKENS AVE. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 5 5 7 | |
|---|---|---|--------------------------------------|---|--|
| 1- FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| NEILIE FRVIN | | 7 23 82 | | 4 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YEAR | |
| FE | BLACK | 5 15 87 | 95 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 49 BLYTHE, GA. | USA | WIDOWED | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTIMORE | 405 Gwynn Ave | Homemaker | at home | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD | | Baltimore | YES | 405 Gwynn Ave | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | | | | |
| Monny Gough | Susan A. Lovett | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| NO | | Anna President 913 Ellicott Dr. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE CARDIO - PULMONARY ARREST 4280 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) NONE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that this hospital attended the deceased from 7/17 19 82 to 7/17 19 82 that I saw the deceased alive on 7/17 19 82 and that in my opinion death occurred on the date and hour and from the causes stated above. I did not view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| HOWARD B. CHEN, M.D. | | ATTENDING PHYSICIAN | | 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Howard B. Chen, M.D. | | BON SECOURS HOSP. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 7/29/82 | | MOUNTAIN VIEW | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | | |
| BALTIMORE MD | | JUL 27 1982 | | | |
| 24. FUNERAL DIRECTOR NAME | | 25. REGISTRAR'S SIGNATURE | | | |
| Mary Ball Phipps 638 N Gilman | | Frances Jan Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. 8 2 1 7 5 5 8 | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Katherine V. Estes | | | | | | 2a DATE OF DEATH MONTH DAY YEAR July 16, 1982 | | 2b HOUR P. 9:15 M. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 7, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker | | 12b KIND OF BUSINESS OR INDUSTRY ----- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY ----- 13c CITY OR TOWN Baltimore | | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 3733 Elkader Avenue | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Christopher T. Estes, Sr. | | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Davis | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17 INFORMANT 12108 Arbie Road- Silver Spring Christopher T. Estes, Jr. Md. 20904. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Masphy 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension, Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus, (Keto) 35-40 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH not def not def 35-40 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/10/1982, 19 to 7/16/82, 19 that (I) (we) lost saw the deceased alive on 6/28/82, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b SIGNATURE Daniel Grune | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/19/82 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e ADDRESS | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE July 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | | 23d LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | |
| 24. FUNERAL DIRECTOR NAME John A. Moran, Inc. 3000 E. Baltimore St. - Baltimore, Md. 21224 | | | | 25a DATE OF DEATH JUL 19 1982 | | | | | |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 5 9

1. FOR
STATE
REGISTRAR

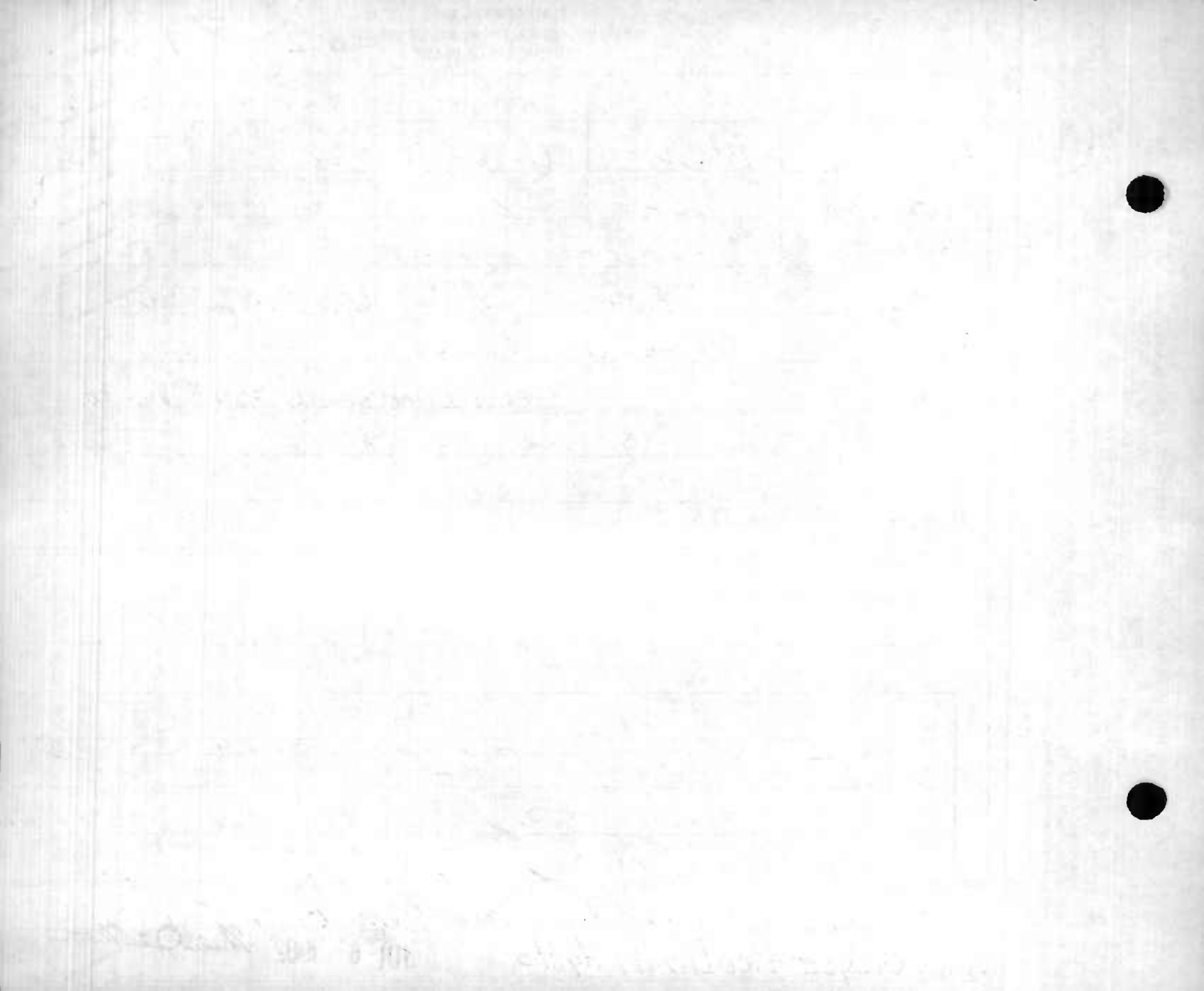
REG NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ESTELLE V. ETHERIDGE | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 4, 1982 | | 2b. HOUR 4 P.M. | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6-6-14 | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. CITY OR TOWN Balto. | | 13c. STREET ADDRESS 2506 Roslyn Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Edward McConnell 3219 Tickers Rd. | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 BILATERAL C.V.A. DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gangrene | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from June 6, 1982 to July 4, 1982, that (I) saw the deceased alive on June 4, 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | |
| 22b. SIGNATURE Irving A. Cohen M.D. | | DEGREE M.D. | | 22c. DATE SIGNED July 4, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVING A. COHEN, M.D. | | 22e. ADDRESS 7306-B PARK HTS BALTIMORE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | 24. FUNERAL DIRECTOR NAME ADDRESS Leroy O. Dyett 4600 Liberty Hgts | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. DATE REC'D. BY REGISTRAR JUL 6 1982 | | | |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LEROY ALBERT EVANS EVANS SR. | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 10, 1982 | | 2b. HOUR 8:15 A.M. | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer | | 12b. KIND OF BUSINESS OR INDUSTRY Newspaper Co |
| 13a. STATE Md. | | 13b. COUNTY ---- | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Michael Evans | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Bentz | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT 3509 Mt. Pleasant Ave.- Mrs. Cathering H. Evans- Balto., Md. 21224. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CACHEXIA, LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CIRRHOSIS OF LIVER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 23 , 19 82 , to JULY 10 , 19 82 , that (I) (we) last saw the deceased alive on JULY 10 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did, did not) view the body after death. | | | | | |
| 22b. SIGNATURE M. L. Bijpuria | | DEGREE M.D. | | 22c. DATE SIGNED JULY 10, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. L. BIJPURIA, MD. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION, 100 N. BROADWAY, BALTIMORE, MARYLAND 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1982 July 13, | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 23e. DATE REC'D. BY REGISTRAR JUL 12 1982 | | | |
| 24. FUNERAL DIRECTOR NAME John A. Moran, Inc. | | ADDRESS 3000 E. Baltimore St. | | 25a. REGISTRAR'S SIGNATURE James J. Keith | |



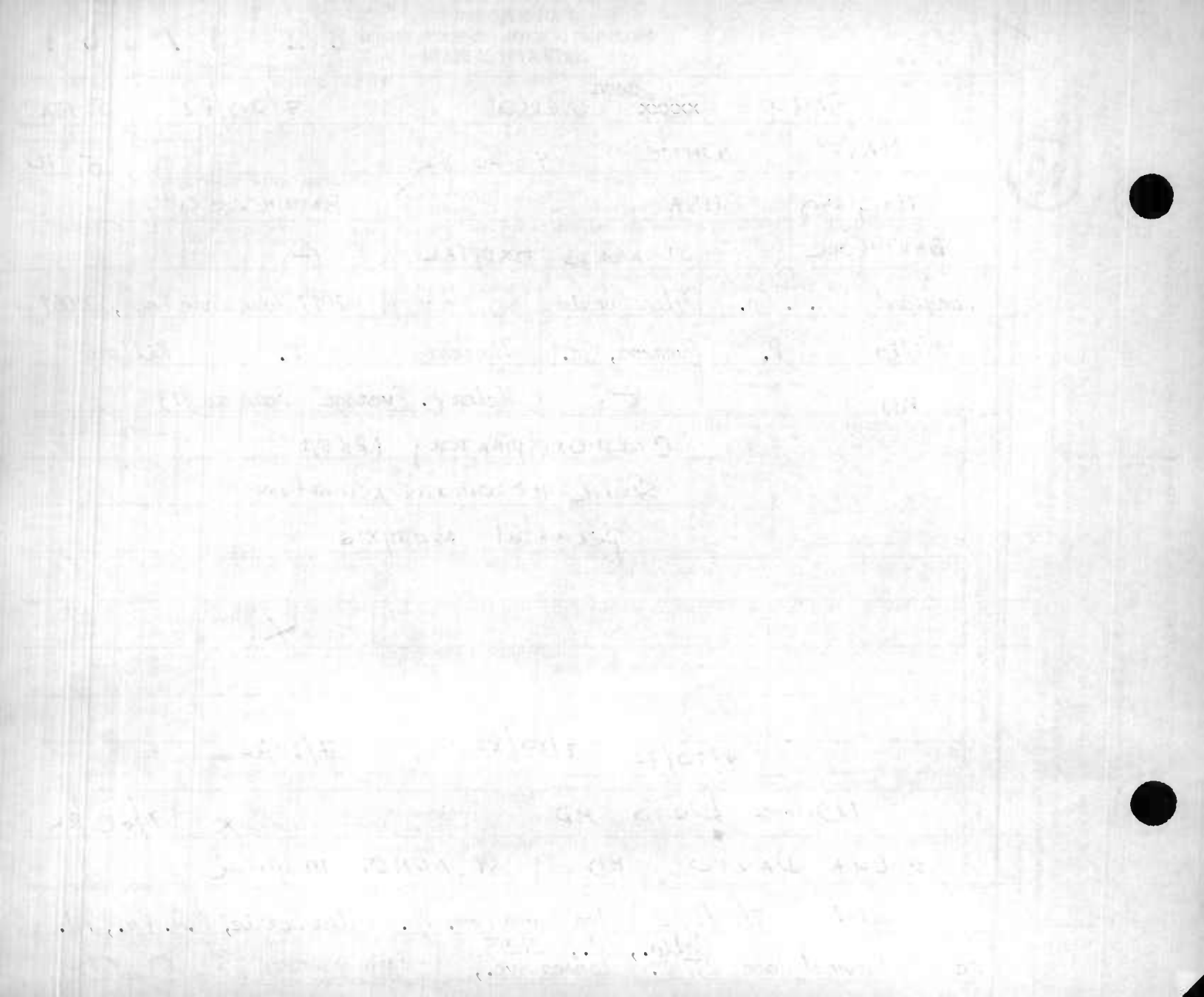
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 5 6 1 | |
|---|--|--|--|--|--|--|--|---|--|------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST BABY BOY EVERSON | | 2a. DATE OF DEATH MONTH DAY YEAR 7/20/82 | | 2b. HOUR 5:45 AM | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 20 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 5 | | 7. UNDER 1 YEAR MONTHS 10 | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE city | | 12. MD. | | | |
| 13. CITY OR TOWN OF DEATH BALTIMORE | | 14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (-) | | 16. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY A.A. Co. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1017 Rose Anne Road, 21061 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip P. Everson, Jr. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa M. Millsap | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (-) | | 17. INFORMANT ADDRESS Helen E. Everson Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7689 IMMEDIATE CAUSE (a) CARDIOROSPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE MECONIUM ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (c) PERINATAL ASPHYXIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (-) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/20/82, 19 to 7/20/82, 19, that (I) (we) lost saw the deceased alive on 7/20/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Wilma Dario MD | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/20/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILMA DARIO MD | | 22e. ADDRESS ST AGNES HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home | | 24b. ADDRESS Balto., Md., 21225 237 E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1982 | | 25b. REGISTRAR'S SIGNATURE Theresa Millsap | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 6 2

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | July 13, 1982 | | 4:07 P.M. | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR JAN 17 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DAIRY SUPERVISOR MILK | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN KEYMAR | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES FREDERICK EYLER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN MACKLEY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-36-8089 | |
| 17. INFORMANT ADDRESS KEYMAR | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from July 12, 1982, to July 13, 1982, that (X) (we) last saw the deceased alive on July 13, 1982, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard A. Lane | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Lane, M.D. | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 16-1982 | | 23c. NAME OF CEMETERY OR CREMATORY MT HOPE | | 23d. LOCATION CITY OR TOWN COUNTY STATE WOODSBORO MD | |
| 24. FUNERAL DIRECTOR NAME D. D. Hartzler | | ADDRESS Woodboro, Md | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | | 25b. REGISTRAR'S SIGNATURE James Santhorn | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 5 6 3

REG. NO.

| | | | | |
|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elizabeth Fairfax | | 2a. DATE OF DEATH MONTH DAY YEAR July 11, 1982 | | 2b. HOUR 7:00 A.M. |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 9 25 1881 | | 6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY? US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | 13b. COUNTY BALTIMORE | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 930 HARLEM AVE. |
| 14. FATHER'S NAME WALTER T. DAVIS | | 15. MOTHER'S MAIDEN NAME HATTIE BROWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT JACQUELINE PORTER |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetes Mellitus (Adult on set) 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dehydration (c) Urinary Tract Infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | |
| Urinary Tract Infection | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 22 , 19 82 , to July 11 , 19 82 , that (X) (we) lost saw the deceased alive on July 11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Joseph Nkwanyu | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED July 11, 1982 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Nkwanyu Md | | 22e. ADDRESS c/o Maryland General Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 7-15-82 | 23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEMT. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | 1721 - 27 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 |
| | | 25b. REGISTRAR'S SIGNATURE Juan Kathan | | |

July 11, 1955

Letter

Director

Baltimore City

Harvard General Hospital

Director

10 Years

Diabetes Mellitus (Adult on foot)

Investigation

Primary tract infection

10 Years

July 11, 1955

June 25

July 11

July 11, 1955

Harvard General Hospital

Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 5 6 4 | | | |
|--|--|---|--|--|--|--|--|
| 1 - STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joseph Frank Famback | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 13 82 | | 2b. HOUR 4:30 P.M. | |
| 3 SEX Male | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 11 6 4 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balt. City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balt. General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY Mass Transit | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. | | 13b. COUNTY Ann Arundel | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Famback | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hechinger | | 13e. STREET ADDRESS 1225 Rockhill Road 21122 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213 05 9306 | | 17. INFORMANT ADDRESS Mrs. Caroline Famback Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestive heart failure, chronic renal failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-26 , 19 82 , to 7-13 , 19 82 , that (I) (we) lost saw the deceased alive on 7-13 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael B. Nester | | | | DEGREE | | 22c. DATE SIGNED 7-13-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Nester | | | | 22e. ADDRESS 3001 S. Hanover St. Balt., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park Glen Burnie | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ann Arundel Md. | |
| 24. FUNERAL DIRECTOR NAME Mtn. & Tick Neck Rd., Pasadena, Md. McCully Funeral Home of Pasadena 21122 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | |

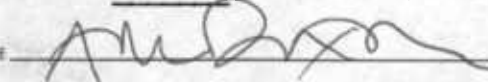

BP

DHMH - 16 25M

(VR A 15 (4)) 9/74

2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

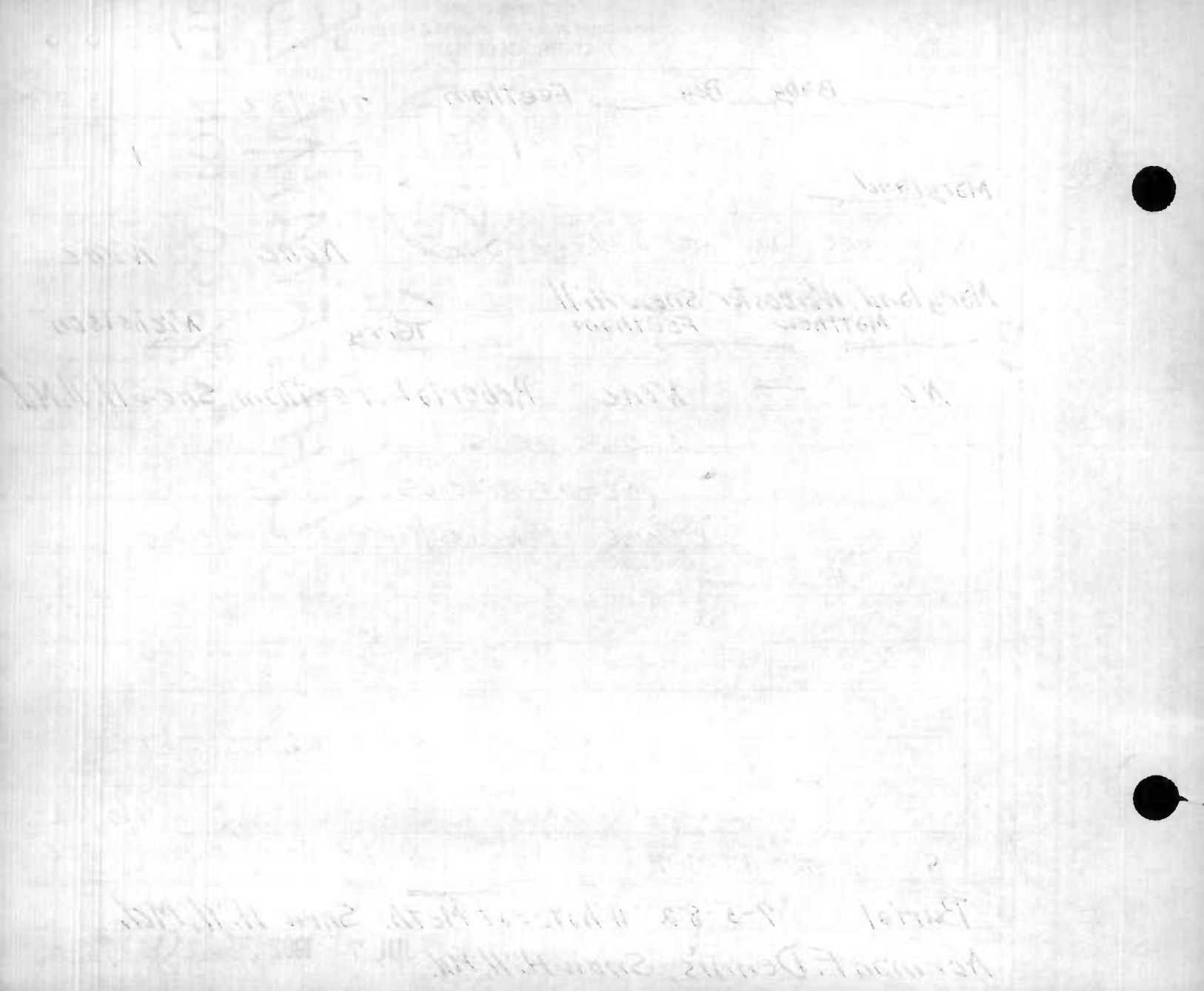
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 17565 | |
|--|------------------|--|---|---|-------------------------------|---|--|---|--|--|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) BETTY FARRELL | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7 27 19 82 | | 2b. HOUR M | | | | | |
| 3. SEX F | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4 23 21 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 61 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD 7 27 19 82 | | 2d. HOUR 11:58 P M | | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4018 Duvall Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE Md. | | | | | | 13b. COUNTY Balto. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 4018 Duval Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. No | | 17. INFORMANT Mamie Toney 4018 Duval Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7-28-82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HGTS. AVE. | | | | 25a. DATE REC'D BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 5 6 6 REG. NO. | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) <u>FEETHAM Baby Boy Feetham</u> | | | | <u>7/2/82</u> | | | | <u>5:25 pm</u> | |
| 3. SEX <u>MARE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>7 1 82</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>25</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OF ORIGIN) <u>Maryland Baltimore</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>CITY</u> MD. | | | |
| 10. CITY OR TOWN OF DEATH <u>BALTIMORE</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MD OF MARYLAND HOOSP.</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>None</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Worcester</u> | | 13c. CITY OR TOWN <u>Snow Hill</u> | | | | | |
| 14. FATHER'S NAME (TYPE OR PRINT) <u>Matthew Feetham</u> | | | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) <u>Nicholson</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | | | 16b. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT ADDRESS <u>Roberta L. Feetham, Snow Hill, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>7690 CARDIAC ARREST</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMOTHORACIES</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYALINE MEMB. DIS/PULMONARY I. EMBOLISM</u> | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bleeding</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1st</u> , 19 <u>82</u> to <u>July 2nd</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>July 2nd</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>S. Tharmarajah</u> | | | | DEGREE <u>M.B.B.S.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>7/2/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. THARMARAJAH</u> | | | | 22e. ADDRESS <u>22 GREENE ST., BALTIMORE</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> | | | | 23b. DATE <u>7-5-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Whateast Meth.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Snow Hill, Md.</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Norman F. Dennis</u> | | | | ADDRESS <u>Snow Hill, Md.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 7 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 5 6 7 | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1 - STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST ALICE | | MIDDLE S | | LAST FELTON | | 2a. DATE OF DEATH MONTH DAY YEAR 7/7/82 | | 2b. HOUR M | |
| 3 SEX F | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY BALTO | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 3609 N. Rogers | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles B. Simpson | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Pippins | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 213-26-9423 | | 17. INFORMANT ADDRESS Jeannette I. Felton 3609 N. Rogers | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> 2080 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leukopenia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>refractory acute leukemia</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>History of Hodgkin's Disease, treated</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>Mar. Apr. 1, 1982</u> to <u>JULY 7, 1982</u> , that (i) (we) last saw the deceased <u>on July 6, 1982</u> and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (we) did <u>not</u> see the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Douglas Orr, MD</u> | | | | | | DEGREE MD | | 22c. DATE SIGNED July 9, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOUGLAS ORR | | | | | | 22e. ADDRESS JOHNS HOPKINS ONCOLOGY CENTER | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | | | | | |
| 24 FUNERAL DIRECTOR NAME JAMES A. MORTON & SONS | | | | | | ADDRESS 1701 LAURENS ST | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | | |
| | | | | | | REGISTRAR'S SIGNATURE James J. Nathan | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and bring them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 5 6 8 REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) August G. Fiedler | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 31, 1982 | | | 2b. HOUR 10:15 AM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 8 21 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired machinist - Western | | 12b. KIND OF BUSINESS OR INDUSTRY Electric | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 334 S. Clinton Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Fiedler | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Magdalena Zimmerman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 215-01-0869 | | 17. INFORMANT ADDRESS Marguerite Wille, 182 W. School St. Alburts, Pa. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma lungs 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Frank X. Patricia, MD | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | DATE SIGNED 8/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank X. Patricia | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Zannino Funeral Home, 263 S. Conkling St | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR SIGNATURE Thomas J. [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

DHMH - 16 50M 1/81
(VRA 15, 4)

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | 8 2 1 7 5 6 9 | |
|---|--|--|---|-------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Frederick A. FISCHETTI | | July 7, 1982 | | 8:00a M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. YRS. | |
| M | WHITE | OCT. 13 1963 | 78 | | |
| 8. BIRTHPLACE (COUNTRY) | 9. BALTIMORE CITY OR COUNTY OF DEATH | 10. CITY OR TOWN OF DEATH | | | |
| MD. | Baltimore City | Baltimore | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 3201 FOSTER AVE. | BARBER | SELF | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MD. | | BALTO. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3201 FOSTER AVE. | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | |
| Tony FISCHEIT | CONCETTA GIULIANO | NO | | | |
| 16a. SOCIAL SECURITY NO. | 17. INFORMANT | 18. CAUSE OF DEATH | | | |
| 215-16-7663 | CATHERINE P. FISCHETTI | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rectal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1541</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| May 18, 1982 | Rectal Carcinoma | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED | | | |
| (IF EITHER NOTIFY MEDICAL EXAMINER) | HOUR A.M. MONTH DAY YEAR | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | P.M. 19 | | | | |
| 21d. INJURY OCCURRED | 21e. PLACE OF INJURY | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from May 17, 19 82, to June 15, 19 82, that (X) (we) last saw the deceased alive on June 15, 19 82, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME | |
| Roy Smoot, M.D. | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 7/9/82 | | c/o Maryland General Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | | |
| BURIAL | 7-10-82 | SAC. HEART OF JESUS | BALTO. COUNTY MD. | | |
| 24. FUNERAL DIRECTOR | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| HOFFMANN-SKARDA | JUL 9 1982 | | [Signature] | | |



Vertical text on the right margin, possibly a date or reference number, including "JUL 1 1963".

Frederick A. FISCHETTI

July 1, 1963

Philadelphia

Philadelphia

NY

Philadelphia

Local Committee

Local Committee

June 12

May 17

June 14

May 20

Handwritten signature or initials.

Philadelphia

Bottom section containing various handwritten notes and dates, including "JUL 1 1963".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 5 7 0 | |
|---|------------------------------|--|------------------------------------|---|---|
| 1. STATE REGISTRAR | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | |
| LUCY | | fisher | | 7-14-82 4:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Female | Black | 5 18 06 | | 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| GA | USA | | | Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | John Z. Newton Medical Center | | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |
| MO | | | Baltimore | | 3228 Frederick Ave |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Dawson Woodward | | Millie Jordan | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | N/A | | Jerry Woodward 2160 Fulton Ave. Cinn., Ohio | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1552 ADENOCARCINOMA OF THE LIVER DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-6 mos |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5-82 | | BILIARY OBSTRUCTION | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-6, 19 82, to 7-14, 19 82, that (I) (we) lost saw the deceased alive on 7-14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | |
| Christine L. Conner | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7-15-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| CHRISTINE L. CONNER MD | | 5411 OLD FREDERICK RD BALTIMORE, MD 21229 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 7/21/82 | King mem. Pr. | | Balt Co. MD |
| 24. FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Wm. C. March F/H 1101 E. North Ave. | | | JUL 20 1982 | | Francis J. Nathan |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17571 | |
|--|--|------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Sean B. Fisher | | | | | | 2g. DATE OF DEATH <input checked="" type="checkbox"/> MONTH 7 DAY 8 YEAR 1982 | | 2b. HOUR 7:32 | | 2c. DATE OF DEATH <input type="checkbox"/> MONTH 7 DAY 8 YEAR 1982 | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH 3 DAY 31 YEAR 82 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS 4 DAYS 4 HOURS 0 MIN. 0 | | 7c. DATE PRONOUNCED DEAD MONTH 7 DAY 8 YEAR 1982 | | 2d. HOUR a | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | | | 13b. CITY OR TOWN Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3100 W. Mount Court | |
| 14. FATHER'S NAME FIRST John MIDDLE Fisher LAST Fisher | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Rita MIDDLE Short LAST Short | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Rita Fisher 3100 W. Mount Court | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 7/8/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN Glen Burnie COUNTY MD STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc. ADDRESS 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Hartman | | | |

4

1915-1916 VI 1 11

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

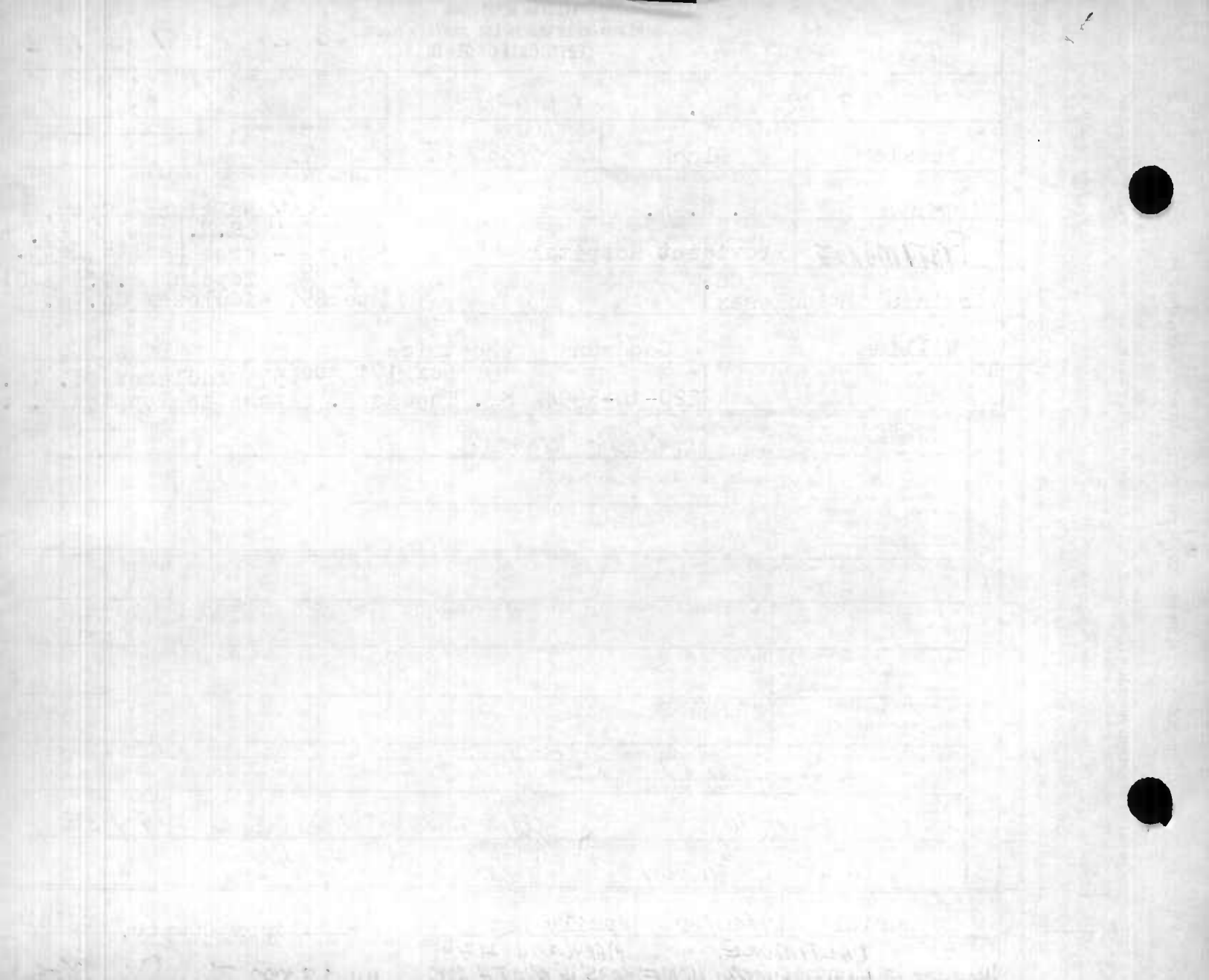
IMPORTANT: If item 21 is marked as item 18, no autopsy injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| FIRST MARY | | 07 06 82 | | 11 45 M | |
| MIDDLE E. | | | | | |
| LAST Fitchette | | | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | Black | MONTH DAY YEAR | 73 | IF UNDER 24 HRS | |
| | | 2 '22 1909 | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | U. S. A. | | Baltimore City, MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | Provident Hospital | | Retired-Nurse | | Health Dept. |
| 13a STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | | 13d. INSIDE CITY LIMITS? |
| Virginia | Middlesex | | 23169 Topping P.O. Box 101 | | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 16b SOCIAL SECURITY NO. | |
| William Goodman | | Beatrice Laws | | 220-10-5994 | |
| 17 INFORMANT | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Box 101 Rte 657 Middlesex Co. Va. | | 4275 IMMEDIATE CAUSE (a) cardiac arrest | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (b) | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | P.M. 19 | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 6-15 19 82, to 7-6 19 82, that (1) (we) last saw the deceased alive on 7-6-82 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| ISAIAH DIMERY | | MD | | 7-7-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| | | 2600 Liberty Hts | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7/10/82 | | Family Lot | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | |
| Middlesex County Virginia | | JUL 13 1982 | | Z. K. Nathan | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | | |
| BALTIMORE, Maryland 21216 | | | | | |
| HERBERT E. NUTTER FUNERAL HOME 3035 W NORTH AVE | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH M. FLETCHER | | | 2a. DATE OF DEATH MONTH DAY YEAR 07/07/82 | | 2b. HOUR 2:34pm |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 2 25 31 | | 6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO. CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY A & P |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Arbutus | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Fletcher | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Ensminger | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1954 213-26-8899 | | 17. INFORMANT ADDRESS Lorraine A. Fletcher 1220 Stevens Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive passive congestion + edema of the lungs DUE TO, OR AS A CONSEQUENCE OF b) Acute myocardial infarction (Clinical) DUE TO, OR AS A CONSEQUENCE OF c) Atherosclerosis | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ± one hour Hours ? |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4100 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR JULY 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE ST AGNES HOSPITAL Baltimore Howard Md. | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 7 1982 , to JULY 7 1982 , that (I) (we) lost saw the deceased alive on JULY 7 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James E Taylor | | DEGREE M.D. | | 22c. DATE SIGNED 7/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES E TAYLOR | | 22e. ADDRESS ST AGNES HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Ambrose Funeral Home 1328 Sulphur Spring Road | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE James E Taylor | |

07/07/82 0:24am

UNITED STATES OF AMERICA

SALT CITY

A. B. ...

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

JUL 8 1982

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 7 5 7 4

REG. NO.

1. FOR
STATE
REGISTRAR

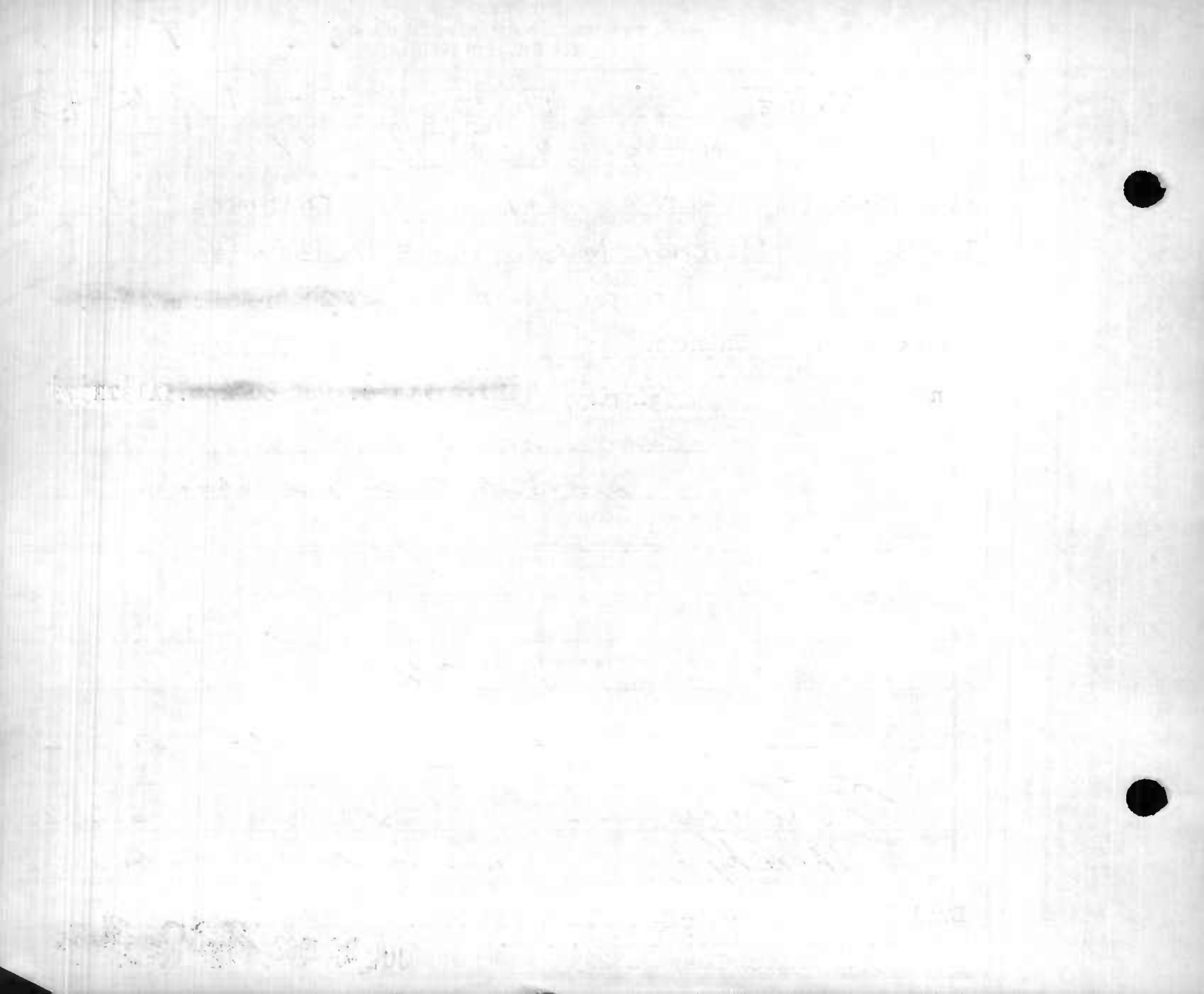
| | | | |
|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) MINNIE L. FLORES <i>Minnie FLORES</i> | | 2a. DATE OF DEATH MONTH DAY YEAR 7-18-82 1 18 82 <i>4 45 A M</i> | |
| 3. SEX F Female | 4. RACE W White | 5. DATE OF BIRTH MONTH DAY YEAR 9-10-1893 <i>9 10 93</i> | 6. AGE (IN YEARS LAST BIRTHDAY) 88 08 YRS. MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | 7b. CITIZEN OF WHAT COUNTRY? U.S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Melchor Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD. | | 13b. COUNTY Balto. | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST unknown Unknown | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 213-10-0734 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterovascular embolism. chronic. DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) n/a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR n/a | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/18 , 19 82 , to 7/18 , 19 82 , that (I) was last saw the deceased alive on 7/15 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death. | | | |
| 22b. SIGNATURE <i>M. Sharoky</i> | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 7/18/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Sharoky | | 22e. ADDRESS 1205 St Paul St Balto 21202 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-20-82 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. |
| 24. FUNERAL DIRECTOR'S NAME Schimunek Funeral Home, Inc. | | 25a. DATE RECEIVED BY REGISTRAR JUL 20 1982 | |
| 3331 Brehms Lane 21213 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|--|----------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 8 2 1 7 5 7 5 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Floyd | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/9/82 | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12/16/20 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 61 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2612 Cylburn Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY Longshoreman | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md | | 13b. COUNTY City | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 764 Carroll St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Reves | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Citty Reves | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 | | 17. INFORMANT ADDRESS Mary Floyd 764 Carroll St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MI due to ASCVD 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body of death. | | | | | | | | | |
| 22b. SIGNATURE F. C. CAGUIN, M.D., P.A. 230 East 25th Street Baltimore, Md. 21218 | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/12/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. C. Caguin, M.D., P.A. | | | | 22e. ADDRESS 230 East 25th Street / Balto., Md 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/14/82 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA | | | | ADDRESS 1300 Eutaw Place | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Keithen | |



P.O. BOX 1111
 130 East 1st Street
 Baltimore, Md. 21202

U.S. AIR MAIL 1000
 1000 U.S. AIR MAIL

CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Edna Foos | | 2a. DATE OF DEATH MONTH DAY YEAR July 25, 1982 | | 2b. HOUR 12:45 <small>P</small> |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 7. 17. 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY Same |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | |
| 13a. STATE MD | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 804 S. Kenwood Ave |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Kelch Mary Bernhardt. | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bernhardt. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 215-09-6188 | | 16c. HOME ADDRESS 804 S. Kenwood Ave |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Non-Oat Cell Carcinoma of Lung**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 months1629
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 21 , 19 82 , to July 25 , 19 82 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 25 , 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Mary Smathers | | DEGREE MD | | 22c. DATE SIGNED 7/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mary Smathers, M.D. | | 22e. ADDRESS C/O Maryland General Hospital | | | |

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-29-82 | 23c. NAME OF CEMETERY OR CREMATORY Lakewood | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md. |
| 24. FUNERAL DIRECTOR NAME ADDRESS Raymond Kaczkowski 2525 LaBelle St. | | 25a. DATE RECEIVED BY REGISTRAR JUL 28 1982 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

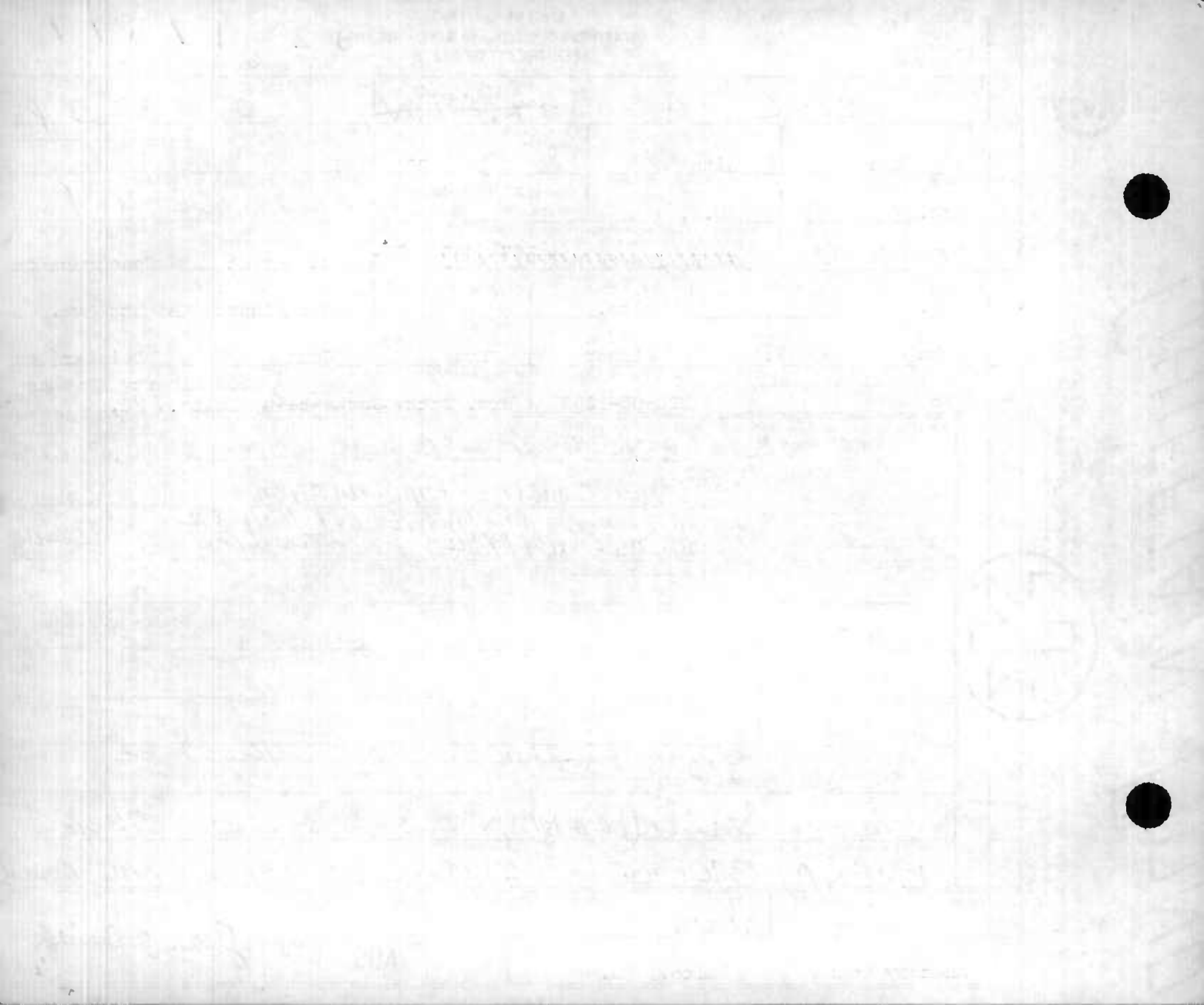
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 1,17 #G570 8/23/82 ph

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRANK A Forbstein | | | 2a. DATE OF DEATH MONTH 07 DAY 20 YEAR 82 | | | 2b. HOUR 5¹³ P.M. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 4 DAY 1 YEAR 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7. IF UNDER 24 HRS HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE 474 MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hosp. 2203 Liberty Heights Ave | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 1a. STATE Md. | | 13b. COUNTY Balto. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2205 Liberty Heights Ave. | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE F. LAST Fisher | | | | 15. MOTHER'S MAIDEN NAME FIRST Eva MIDDLE June LAST Poirier | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 220-03-9263 | | 17. INFORMANT ADDRESS Forbstein 2205 Liberty Heights Av. Mrs. Betty Forbstein Balto., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 5336 DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) PERFORATE PERITONEAL DISEASE WITH ABSCESS FORMATION & PERITONITIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 mins 30 mins 2 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/18 , 19 82 , to 7/20 , 19 82 , that (I) (we) lost saw the deceased alive on 7/20 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Emeka Okeke (MD) | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/20/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EMEKA OKEKE | | | | | | 22e. ADDRESS 2600 LIBERTY HEIGHTS, BAL MD 21225 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 7/21/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME Anatomy Board | | | | | | ADDRESS Balto., Md. | | 25a. DATE REC'D. BY REGISTRAR AUG 6 1982 | | 25b. REGISTRAR'S SIGNATURE John J. Smith | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 5 7 8 | | | |
|--|--|--|--|--|--|---|--|--|--|-----------------|-----|--------------------|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| BABY BOY A | | FORD | | | | | | 01 | | 03 | 82 | 405 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| M | | B | | 01 01 82 | | 2906 | | MONTHS | | DAYS | | HOURS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD | | USA | | | | BALTIMORE CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| BALTO | | SINAI | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| MD | | BALTO CITY | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2906 WELMAN AVE | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| DONALD | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 7690 | | Hypoxia | | | | | | 3 hrs | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | Pulmonary Hemorrhage | | | | 12 hrs | | | | | |
| | | (c) | | Hyaline Membrane Disease, Prematurity | | | | 36 hrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | Suspected Sepsis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.] | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | JAN 1 | | 19 82 | | to | | JAN 3 | | 19 82 | | that (I) (we) lost | |
| saw the deceased alive on | | JAN 3 | | 19 82 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| D. Hummell MD | | | | 1/3/82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| LUNIS | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | |
| 2 | | | | SINAI HOSP | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | JUL 30 1982 | | Name of Registrar | | | | | |

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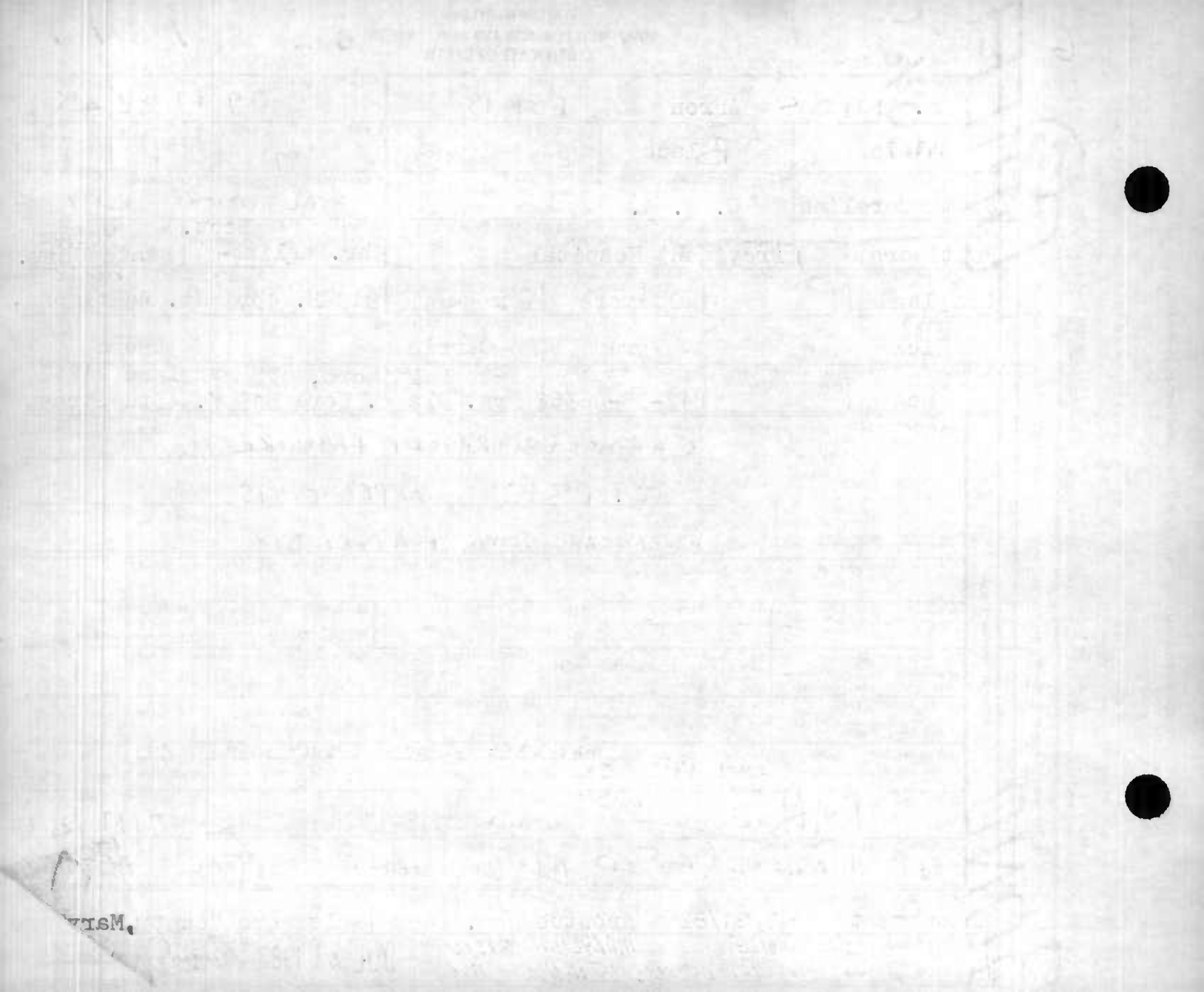
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 82 17579 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Dr. NICK Aaron | | FORD | | | | | | 07 17 82 4:5 PM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | Black | | 8 4 1904 | | 77 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| South Carolina | | U. S. A. | | | | BALTIMORE CITY MD | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Provident Hospital | | | | Chr. English- | | Morgan State Univ. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | | | Baltimore | | | | Maryland 21212 919 E. 43rd St. Baltimore, | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Nick Ford | | Carrie Ford | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| No | | 212-38-0636 | | Baltimore, Maryland 21212 Mrs. Ola M. Ford 919 E. 43rd Street | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) 1535 CARDIORESPIRATORY FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS, APPENDICITIS | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ADENOCARCINOMA OF APPENDIX | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 23RD 1982, to JULY 17TH 1982, that (I) (we) last saw the deceased alive on JULY 17TH 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| BEN MAGNUS-LAWSON MD | | MD | | | | | | 7/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| BEN MAGNUS-LAWSON MD | | PROVIDENT HOSPITAL BALTIMORE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Entombment | | 7/21/82 | | Arbutus Mem. Park | | Baltimore County, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Herbert E. Nutter Funeral Home | | 3035 N. NORTH AVE. | | JUL 21 1982 | | Rosa J. Gantner | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH 16-50M (1/81)
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 5 8 0
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| ARCHIE FORREST | | JULY 8, 1982 | |
| 3. SEX | | 2b. HOUR AM | |
| M. | | 5:00 AM | |
| 4. RACE | | 5. DATE OF BIRTH | |
| NEGRO | | JULY 25 1992 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Md. | | 90 YRS. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| BALTO. | | BALTO. MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | |
| BALTO. | | CHURCH HOSP | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Valet | | Hess Shoes | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. INSIDE CITY LIMITS? | |
| 13a. STATE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md | | 13c. STREET ADDRESS | |
| 13b. COUNTY | | 236 Beale CT | |
| 13c. CITY OR TOWN | | BALTO. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| George FORREST | | MARY ARMSTRONG | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| No | | 212-89-3521 | |
| 16c. IF YES, GIVE WAR OR DATES | | 17. INFORMANT ADDRESS | |
| | | BESSIE L. Forrest 236 Beale CT | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | |
| 4029 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) HYPERTENSION | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| | | P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED | |
| | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 7, 1982, to JULY 8, 1982, that (I) (we) last saw the deceased alive on JULY 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | |
| John R. Bartholomew MD | | 7/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | |
| JR BARTHOLOMEW | | CHURCH HOSPITAL CORPORATION 100 NORTH BROADWAY, BALTIMORE, MD 21231 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Burial | | 7/12/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | |
| Arbutus Mem PR | | Arbutus, Md | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | |
| Locks Funeral Home 1304 N. Central CT | | JUL 12 1982 | |
| 25b. REGISTRAR'S SIGNATURE | | | |
| | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

2702 DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17581

| | | | | | |
|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Charles Joseph Foster | | 7 20 82 | | 6:55 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Male | White | Jan. 18, 1927 | 55 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| New Jersey | USA | Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | 4305 Harford Road | Bar Tender | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Ma | | Baltimore | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4305 Harford Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Foster | | Helen Dailey | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | |
| yes | WW II | Mrs. Claire M. Foster | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Ann M. Dixon, M.D. | | Assistant | | 7/21/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| | | 111 Penn St. Balto., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | July 23, 1982 | | Cheltenham | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck Inc. Baltimore, Maryland | | JUL 21 1982 | | James J. Nathan | |

ORIGINAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 5 8 2 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | | | |
| Catherine E. FOWLER | | | | July 27, 1982 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | MONTH DAY YEAR 3 11 09 | | 73 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Maryland General Hospital | | Homemaker | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Maryland | | | | Baltimore | | 5220 York Road Apt. 3I | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Charles Izenhood | | Virginia Young | | | | | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Virginia S. Knauss | | 7734 Washington Blvd. | | Myocardial Infarction | | few minutes | |
| | | | | (b) DUE TO, OR AS A CONSEQUENCE OF Post-operative right colectomy and partial cystectomy | | 5 Days | |
| | | | | (c) DUE TO, OR AS A CONSEQUENCE OF Coronary artery disease. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| July 22, 1982 | | Carcinoma of the Cecum and the Urinary Bladder | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (the doctor) attended the deceased from June 28, 19 82, to July 27, 19 82, that (I) (x) lost saw the deceased alive on July 27, 19 82, and that in (my) (o) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| James Powder, M.D. | | M.D. | | | | 7-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| James Powder, M.D. | | c/o Maryland General Hospital | | Burial | | 8/3/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY | | 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Loudon Park Cemetery | | Baltimore Maryland | | Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229 | | AUG - 2 1982 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | | | |
| | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a death certificate must be filed with the State Dept. of Health and Mental Hygiene.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 5 8 3 REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sally A. Fowlkes | | | | 2b. HOUR 4:30 PM | | | |
| 3 SEX Female | | 4 RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 10 3 1907 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md. Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Stevenson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Mabry | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) unknown | | | | 16b. SOCIAL SECURITY NO. 579 200568 | | 17 INFORMANT ADDRESS Mr. Fowlkes 2309 Lexington St. | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumoniae Ca.</u> 1579 DUE TO, OR AS A CONSEQUENCE OF none Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) none (c) none DUE TO, OR AS A CONSEQUENCE OF none APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 14, 19 82, to July 15, 19 82, that (I) (we) last saw the deceased alive on July 15, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Charles E. Sheehan M.D. | | | | 22c. DATE SIGNED 7/15/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Sheehan M.D. | |
| 22e. ADDRESS University of Md. Hosp. | | | | 22f. DATE REC'D. BY REGISTRAR 7/19/82 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mamm | | 23d. LOCATION City or Town County State Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME C. Wainwright 2700 Edmondson Ave ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 7/19/82 REGISTRAR'S SIGNATURE Thomas J. Thornton | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 5 8 4 REG. NO. | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 7b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALD FOX | | | | JULY 6, 1982 | | | | 6:45PM | | | |
| 3 SEX MALE | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAR. 30, 1946 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 36 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW FOUNDLANDS | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE SALES | | 12b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALFRED FOX | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVE GREEN | | | | 13e. STREET ADDRESS 6914 BROOKMILL RD. #21215 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 216-44-2121 | | 17. INFORMANT MRS. ELLEN FOX | | | | 17. ADDRESS 6914 BROOKMILL RD. BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 4 YRS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 14 , 19 82 , to JULY 6 , 19 82 , that (I) (we) lost saw the deceased alive on JULY 6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard A. Lange | | | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. LANGE | | | | | | | | 22e. ADDRESS 600 N. WOLFE ST | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JULY 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK | | 23d. LOCATION RANDALLSTOWN CO. BALTO. MD | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

PA 2P OCT 0
044722 A 1
M 000000000

UNITED STATES
MOTOR CO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Nathan FOX</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7/13/82</i> | | 2b. HOUR <i>1209 AM</i> | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>AUGUST 25, 1919</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY MD.</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Sinai Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SELF-EMPLOYED</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i> | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY | | 13c. CITY OR TOWN <i>BALTIMORE</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>6963 GLENHEIGHTS AVE. 21215</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>MORRIS FOX</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ROSE LEVIN</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i> | | 16b. SOCIAL SECURITY NO. <i>WWII</i> | | 17. INFORMANT ADDRESS <i>MR. GILBERT FOX 8901 MAPLEBROOK RD. 21133</i> | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>5770 IMMEDIATE CAUSE (a) Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>intracerebral bleed</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>pancreatic abscess</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>a</i> | | | | | | | | | |
| 19a. DATE OF OPERATION <i>7/13/82</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding into peritoneum</i> | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>NOT WHILE AT WORK</i> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED <i>NOT WHILE AT WORK</i> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) | | | | | |
| 22a. I certify that (I) [this hospital] attended the deceased from <i>6/4/82</i> , 19 <i>82</i> , to <i>7/13/82</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>July 13</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Ruth L. Hilleston</i> | | | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>7/13/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ruth L. Hilleston</i> | | | | 22e. ADDRESS <i>Sinai Hospital</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | 23b. DATE <i>JULY 14, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>HEBREW YOUNG MENS CEM. BALTIMORE</i> | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) <i>BALTIMORE MARYLAND</i> | | 24. FUNERAL DIRECTOR NAME ADDRESS <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</i> | |
| 25a. DATE REC'D. BY REGISTRAR <i>JUL 20 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Ruth L. Hilleston</i> | | | | | | | |



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 5 8 6 | | | |
|---|--|---|--|---|--|---|--|--|--|------------------|-----|--|----------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| Lorraine Bertha France | | | | | | | | 7-26-82 | | | | | 6:50 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| female | | white | | MONTH 2 DAY 5 YEAR 23 | | 59 | | MONTHS | | DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Balto., Md. | | USA | | | | Baltimore City | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Maryland | | 5603 Force Rd. | | Housewife | | homemaking | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5603 Force Rd. | | 21206 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | | | | | |
| William Theodore Johnson | | Rose Margaret Herbert | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| no | | 214-18-3960 | | William H. France, 5603 Force Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>81</u> , to <u>7/26</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | | | | | |
| <u>Davis M. Hahn</u> | | MD | | 7/20 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| Davis M. Hahn | | 5801 Loch Raven Blvd | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 7-29-82 | | Gardens of Faith | | Overlea Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | | | REGISTRAR'S SIGNATURE | | | | | |
| Lassahn Funeral Home, 7401 Belair Rd. | | | | JUL 30 1982 | | | | <u>Thane J. Smith</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|--|--|---|--------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 5 8 7 | | | | | |
| 1. DECEASED NAME | | | | | 2a. DATE OF DEATH | | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | | |
| Mary J. Francis | | | | | D.O.A. 7 15 82 12-30 M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE IN YEARS (LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Female | | White | | 12 8 1894 | | 88 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | U.S.A. | | | | Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Baltimore City Hospital | | | | Housewife | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | | Baltimore | | Dundalk | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | | |
| Anton Chalose | | | | | Katherine | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | None | | Patricia K. Phelps Balto., MD. 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| 4100 IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.U.D.</i> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/23, 19 82, to 6/23, 19 82, that (I) (we) last saw the deceased alive on 6/23, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <i>Carlos Patalinghug</i> | | | Dr. Carlos Patalinghug | | | | 403-B. Filapsoa Balto MD 21225 | | | |
| 22d. PHYSICIAN'S NAME (TYPE AND LAST NAME) | | | 22e. ADDRESS | | | | | | | |
| Dr. Carlos Patalinghug | | | 403-B. Filapsoa | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 7/19/1982 | | Woodlawn | | Baltimore Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| Duda-Ruck, Inc. | | | | | | JUL 20 1982 | | | | |
| 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | REGISTER'S SIGNATURE <i>James J. Warren</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST WILLIAM FRANKTON | | | | | MONTH DAY YEAR HOUR July 16, 1982 3:35 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | MONTH DAY YEAR 8 14 1917 | | 64 YRS | | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. CITIZEN OF WHAT COUNTRY? | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | Nurse (Retired) | | Hospital | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 17. STATE | | 18. COUNTY | | 19. CITY OR TOWN | | 20. INSIDE CITY LIMITS? | |
| Maryland | | Carroll | | Sykesville | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. STREET ADDRESS | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | | | | | |
| FIRST MIDDLE LAST William H. Frankton, Sr. | | FIRST MIDDLE LAST Elizabeth Harbaugh | | 7700 Sykesville Road Sykesville, Maryland | | | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) | | 18. INFORMANT | | | | | |
| Yes | | 217-01-0978 | | Iva Frankton | | | | | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) hemorrhage | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) infection status post aortic bypass surgery | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) thrombosed aortic aneurysm + necrotic bowel | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. DATE OF OPERATION | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20c. AUTOPSY? | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| May 29, 1982 | | abdominal aortic aneurysm | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) <input checked="" type="checkbox"/> this hospital attended the deceased from May 29, 1982, to July 16, 1982, that (I) <input checked="" type="checkbox"/> saw the deceased alive on July 16, 1982, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Charles Schwarz, MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Schwarz, MD | | | | | | 22e. ADDRESS Union Memorial Hospital, Balto, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 7-20-82 | | Lake View Memorial Park | | Eldersburg, Carroll, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Haigt Funeral Home | | | | | | 25. DATE REC'D. BY REGISTRAR ADDRESS Sykesville, Maryland JUL 19 1987 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 | 2 | 1 | 7 | 5 | 8 | 9 |
|---|--|--|---|--|--|---|--|--|--|---|---|--|--|---|---|---|
| FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) PHYLLIS Philomena FRANKOWSKI | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 82 | | | | 2b. HOUR 2:50am | | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH MONTH DAY YEAR 2 25 1919 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) house-wife | | | 12b. KIND OF BUSINESS OR INDUSTRY home | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1335 Broening Highway 21224 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Dominic Mezzenotte | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DiSaia | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS Cheater M. Frankowski 1335 Broening Highway | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST, LEFT HEMIPARESIS 4292 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE, ARTERIOSCLEROTIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-25 , 19 82 , to 7-26 , 19 82 , that (I) (we) last saw the deceased alive on 7-26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Mukesh Luhar MD | | | | | | | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/25/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MUKESH LUHAR MD | | | | | | | | | | 22e. ADDRESS CHURCH HOME HOSPITAL 100 N. BROADWAY BALTIMORE MD. 21231 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/29/82 | | | 23c. NAME OF CEMETERY OR CREMATORY St Stanislaus | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Walter Paluszki 1005 Dundall Ave | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 4 1982 | | | | 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | |

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Church Hospital

house-wife.

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Baltimore

1935 Blooming Highway

Monism

0710195592

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Chester N. Frankowski 1335 Broening Highway



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use on the burial permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 5 9 0 | | | |
|--|--|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence W. Frazee | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07/31/82 | | 2b. HOUR 3:12P | |
| 3 SEX MALE | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 8-16-14 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BETHLEHEM | | 12b. KIND OF BUSINESS OR INDUSTRY SHIP YARD. | |
| 13a. STATE Md 13b. COUNTY AA 13c. CITY OR TOWN Glen Burnie | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1228 Guilford Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wm. H. Frazee | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Stapp | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 217074999 | | 17. INFORMANT Dorothy Frazee - Elmer | | ADDRESS Staff | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Cardiac arrhythmias DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/29 , 19 82 , to 7/31 , 19 82 , that (I) (we) lost saw the deceased die on 7/31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Niles | | DEGREE J. Niles | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/31 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Niles | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-4-82 | | 23c. NAME OF CEMETERY OR CREMATORY Drum Ridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Md | |
| 24. FUNERAL DIRECTOR Robert A. Baranowski | | ADDRESS Severna Park | | 25a. DATE REC'D. BY REGISTRAR AUG 4 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

1010

RECEIVED BY THE DIRECTOR

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RECEIVED BY THE DIRECTOR

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CCNY



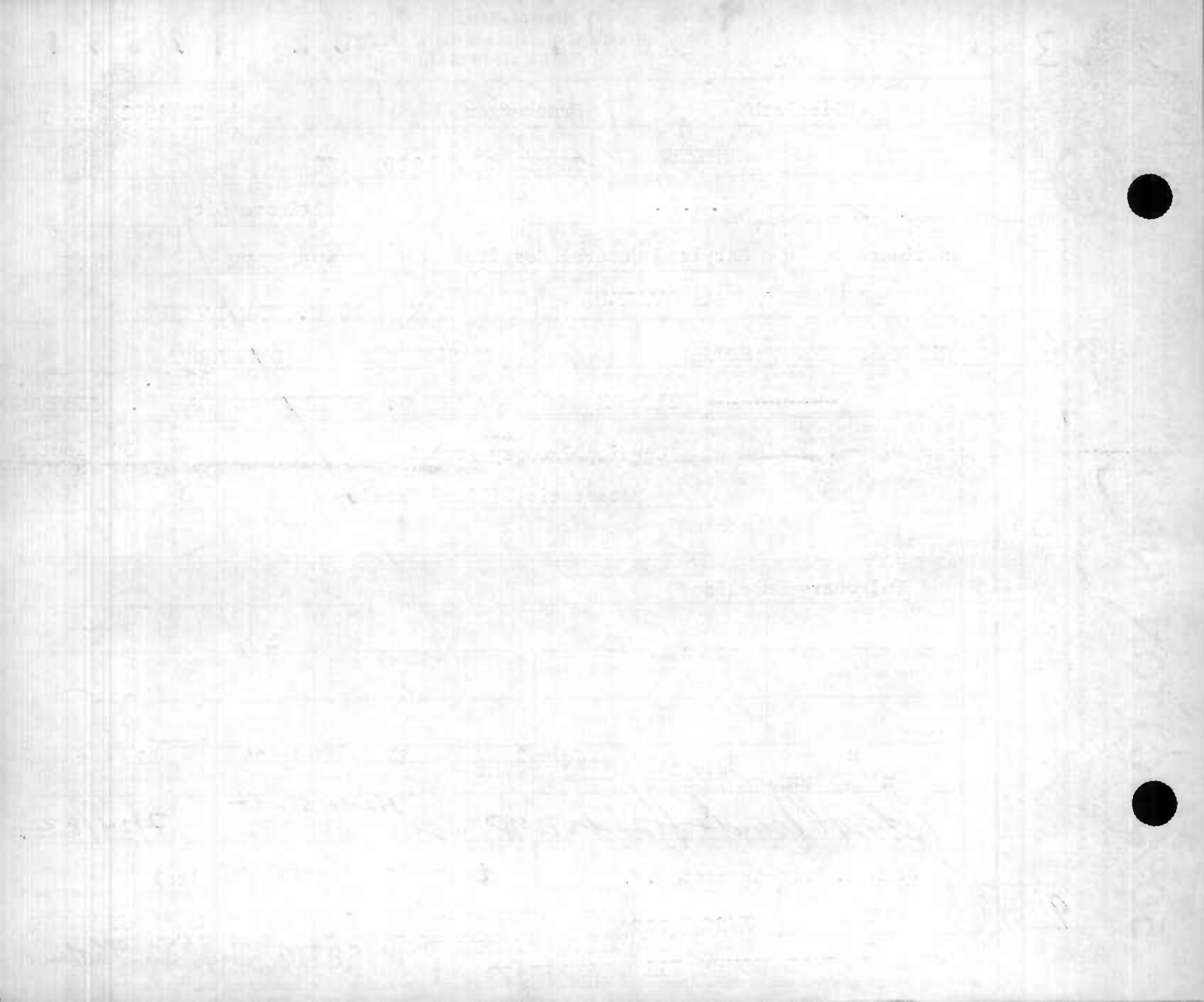
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 2 | 1 | 7 | 5 | 9 | 1 |
|--|--|--|---|--|--|---|--|---|--|--|---|--|---|---|---|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Elizabeth Freeburger | | | | | | | | | | 2a DATE OF DEATH MONTH DAY YEAR July 24, 1982 2b HOUR 8:28 p.m. | | | | | | |
| 3 SEX FEMALE | | | 4 RACE WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR APRIL 21, 1920 | | | 6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MARYLAND | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | | 12b KIND OF BUSINESS OR INDUSTRY AT HOME | | | | |
| 13a STATE MARYLAND | | | 13b COUNTY BALTIMORE | | | 13c CITY OR TOWN OVERLEA | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e STREET ADDRESS 22 W. ELM AVENUE | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST CHARLES HENRY SPAHN | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE DENHARDT | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | | |
| 16b SOCIAL SECURITY NO. 219 03 0028 | | | | | | 17 INFORMANT ALBERT G. FREEBURGER | | | | | | ADDRESS 22 W. ELM AVE. BALTO. MARYLAND | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1569 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Biliary Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary Embolism | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 2 , 19 82 to July 24 , 19 82 , that <input checked="" type="checkbox"/> (we) lost above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death July 24 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE John P. Knud-Hansen, M.D. | | | | | | DEGREE House Staff ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 7/24/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Knud-Hansen, M.D. | | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 7/28/1982 | | 23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS DIPPEL FUNERAL HOMES 7110 BELAIR RD | | | | | | 25a. DATE RECD. BY REGISTRAR 7/28/1982 | | | | | | 25b. REGISTRAR'S SIGNATURE Frances Jan. Nathan | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|---|---|---|---------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 5 9 2 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA JEANETTE FREY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 82 | | 2b. HOUR A 7:15M | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 2 26 08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor -Ret. | | 12b. KIND OF BUSINESS OR INDUSTRY W.J. Dickey | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 200 E. Medwick Garth | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Hanson Boyer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Kelbaugh | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-09-6260 | | 17. INFORMANT Mrs. Roy Filbert | | ADDRESS 636 Ingleside Ave, Baltimore, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Intracerebral bleed DUE TO, OR AS A CONSEQUENCE OF (b) Aneurism of left posterior communicating artery DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 6, 1982, to July 28, 1982, that (I) (we) lost saw the deceased alive on July 27, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Steven M. Samuels M.D. | | | | 22c. DATE SIGNED 7/28/82 | | | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STEVEN SAMUELS | | | | 22f. ADDRESS 900 SO. CATON AVE BALTO MD 21229 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md. | | | |
| 24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 30 1982 James J. Kathan | | | | | |
| 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | | | |



Investigator - Mr. J. J. Hoover

Washington, D.C. 20535

Mr. J. Edgar Hoover
Director
Federal Bureau of Investigation
Washington, D.C. 20535

RECEIVED
FBI
JAN 10 1962



1000 Pennsylvania Avenue, N.W., Washington, D.C. 20004
J. Edgar Hoover, Director
Federal Bureau of Investigation
U.S. Department of Justice

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7 2 1 7 5 9 3 | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>Gloria F. Friend</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>7-24-82</u> | | | | 2b. HOUR <u>12:05 P</u> M | |
| 3. SEX <u>F</u> | | 4. RACE <u>B</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>2 01 44</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>38</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS <u>0 0</u> | | IF UNDER 24 HRS. HOURS MIN. <u>0 0</u> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Hosp</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>Hampton</u> | | 13b. CITY OR TOWN <u>Baltimore</u> | | 13c. INSIDE CITY LIMITS? <u>YES</u> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>6731 Brompton Rd</u> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>Samuel A. Ford</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Louise Ford</u> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>218 421217</u> | | 17. INFORMANT ADDRESS <u>inpatient registration record</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1749</u> IMMEDIATE CAUSE (a) <u>irreversible cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma of Breasts.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 23</u> , 19 <u>82</u> , to <u>July 24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>July 24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Arthur F. Woodward Jr MD</u> | | | | DEGREE <u>surgical Resident.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur F Woodward Jr MD</u> | | | | 22e. ADDRESS <u>22 S. Greene St. Baltimore Md 21201</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>7-29-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Anne Arundel Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Carlton C. Douglass</u> | | | | ADDRESS <u>669-1738 1012 Penn Ave.</u> | | | | DATE OF DEATH <u>20 1982</u> | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17594 | |
|---|------------------|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thaddeus H. Frippe | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7 7 19 82 | |
| 3. SEX male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 12 06-73 | 6. AGE (IN YEARS) LAST BIRTHDAY YES | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN | 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD 7 7 19 82 | | 2d. HOUR 5:15 a.m. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Car. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5439 Nelson Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY Balto. | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS 5439 Nelson Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 088 14 3356 | | 17. INFORMANT ADDRESS Mary Frippe 5439 Nelson Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u> | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 7-7-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Anne J. [Signature]</u> | | | | | |



RECEIVED
FEB 11 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 8 2 1 7 5 9 5 | | | | |
|--|--|--|---|---|--|--|--|--|---|--|------------------------------------|-----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Maxim E. Frisch</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7-15-82</i> | | | | | 2b. HOUR <i>1:25 A M</i> | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>July 6, 1896</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTO CITY</i> MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i> | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Lady</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i> | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Ind. BALTO</i> | | | | | 13c. CITY OR TOWN <i>Owings Mills</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>613 Hammershire Rd</i> | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Herbert L. Bull</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma C. Cullen</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | | | 16b. SOCIAL SECURITY NO. <i>220-07-2597</i> | | 17. INFORMANT ADDRESS <i>Louise Jones 613 Hammershire Rd. Owings Mills, Ind.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4860</i> IMMEDIATE CAUSE (a) <i>Pneumonia</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/17</i> , 19 <i>82</i> to <i>7/15</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>7/15</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>M. J. Schmitt</i> | | | | | DEGREE <i>M.D.</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <i>7/15/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MOSES G. BREMMER</i> | | | | | 22e. ADDRESS <i>Lutheran Hospital, BALTO, Ind.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i> | | | 23b. DATE <i>July 17, 1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i> | | | 23d. LOCATION CITY OR TOWN STATE <i>Pikesville Baltimore</i> | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>H. E. Schmitt</i> | | | | | ADDRESS <i>Owings Mills, Ind.</i> | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 19 1982</i> | | | | | | |

1893

July 1st

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,
Yours truly,

Wm. L. G. Brown

Secretary

Chicago, Ill.

1893

Enclosed

for you

are

the

originals

of the

documents

referred to in your letter of the 28th inst.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| Items #16a-22a Film G571 9/24/82 r DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 1 7 5 9 6 | |
|--|------------------|---|---|--|---|--|---|--|--|--------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) VERONICA A GACKOWSKI | | | | | | 2a. DATE KNOWN OF DEATH 7-12-82 | | 2b. HOUR 19 | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Aug 8, 1912 | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | 7. UNDER 1 YR. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD 7-12-82 | | 2d. HOUR 12:40 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 5638 Kavon Avenue | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Dombrowski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica ? ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-6485 | | 17. INFORMANT Mr Michael J Gackowski | | ADDRESS Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? (BODY ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> (BODY ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie McNeill | | | TITLE (SPECIFY) M. Assistant | | | | | DATE SIGNED 7-13-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. | | | ADDRESS 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY St Stanislaus | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE Name J. [Signature] | | | | | |

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 5 9 7 | |
|---|--|---|---|--|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William Gadsden | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/20/82 | | | 2b. HOUR 7:28 AM | | | |
| 3. SEX M | | 4. RACE N | | 5. DATE OF BIRTH MONTH DAY YEAR 9 8 22 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 74 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (COUNTRY) md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BAITO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1340 N. Luzerne Ave | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE md. | | | 13b. COUNTY | | 13c. CITY OR TOWN BAITO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1340 N. Luzerne Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Luke Gadsden | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Webster | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 218-18-253 | | 17. INFORMANT ADDRESS Marguerite Webster 1340 Luzerne Ave | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Undifferentiated Lung Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | | | |
| 19a. DATE OF OPERATION — | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 82 , to 7/14 , 19 82 , that (I) (we) lost saw the deceased alive on 7/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Andrew D Beamer MD DEGREE MD | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/20/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW BEAMER | | | | | 22e. ADDRESS 1129 N. Caroline St. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7-26-82 | | 23c. NAME OF CEMETERY OR CREMATORY EAST View Mem. PK. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE 5600 Cardiss md | | | |
| 24. FUNERAL DIRECTOR NAME PATRICIA BETTS | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 22 1982 | | | 25b. REGISTRAR'S SIGNATURE Theresa J. [Signature] | | | |

STATE OF NEW YORK

1911

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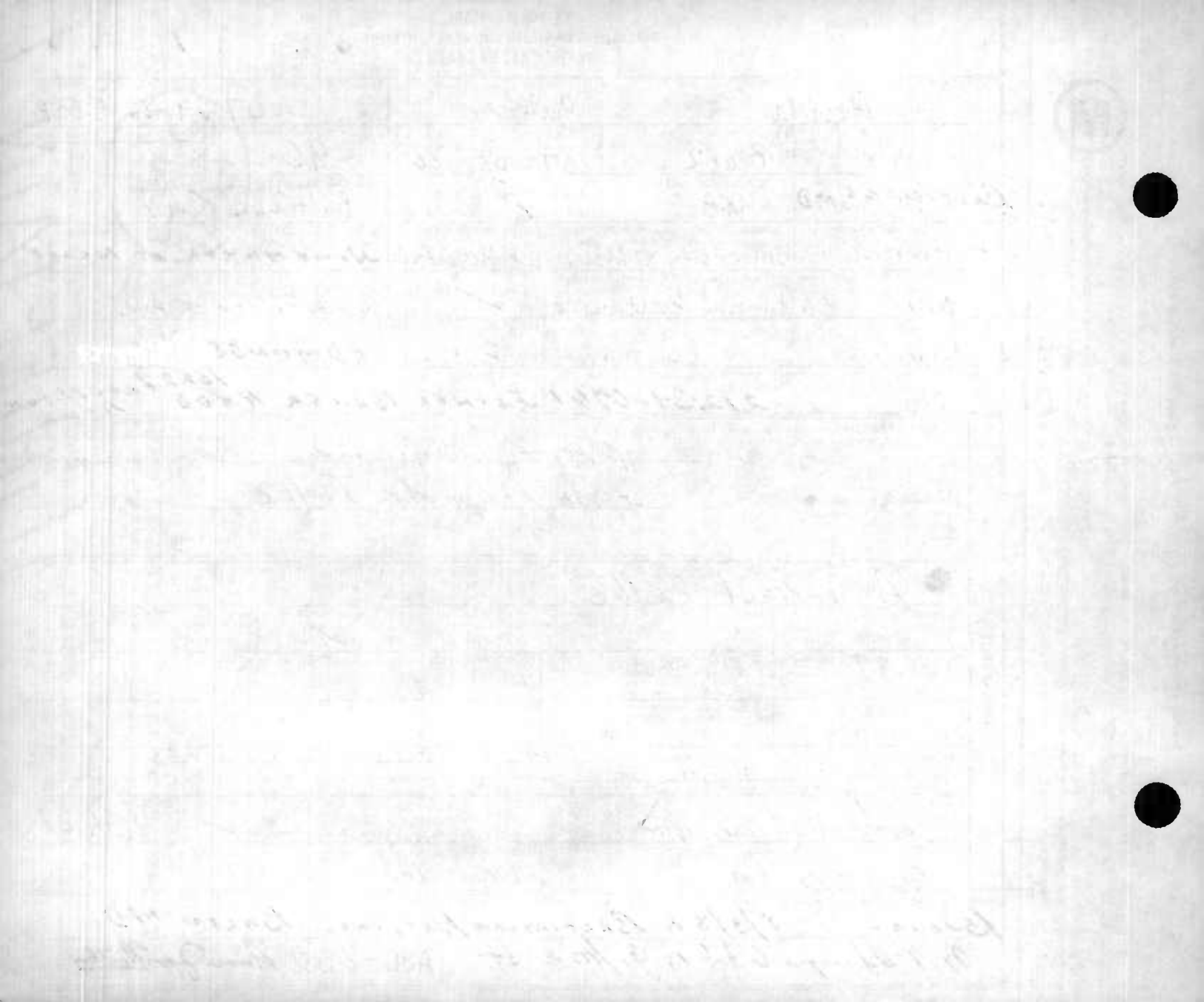
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Aguilla Gaisher | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 29 82 2b. HOUR 5:55 PM | | | | |
| 3 SEX Female | | 4 RACE Black | | 5 DATE OF BIRTH MONTH DAY YEAR 07 03 36 | | 6 AGE (IN YEARS LAST BIRTHDAY) 46 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WORKER AT NEWS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1622 Frederick Ave | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Charles Coleman | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther EDMONDS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-34-6761 | | 17 INFORMANT ADDRESS 1622 Frederick Ave | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertension / Bradycardia | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) ? | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Renal Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/29 , 19 82 , to 7/29 , 19 82 , that (I) (we) last saw the deceased alive on 7/29/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard Carey MD | | | | DEGREE | | | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD CAREY | | | | 22e. ADDRESS Univ. Md. Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | |
| 24. FUNERAL DIRECTOR Mr. Henge 638 N. Gilmor St | | | | 25. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | REGISTRAR'S SIGNATURE James J. Gaisher | | | |

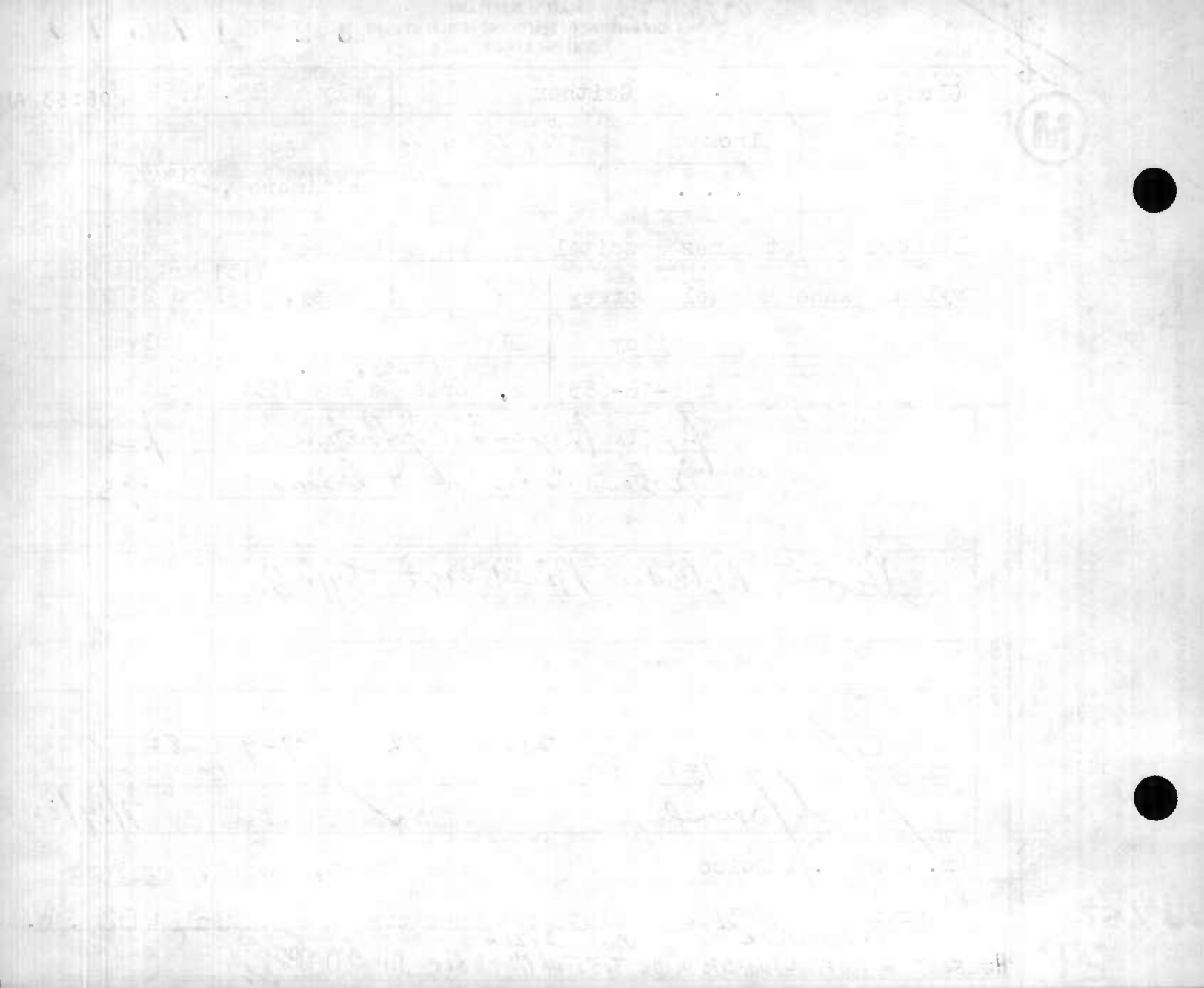


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|--|----------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Gladys V. Gaither | | | | | 2a. DATE OF DEATH July 19, 1982 | | 2b. HOUR 06:53 AM | | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 11 15 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY Baltimore, City MD | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser | | 12b. KIND OF BUSINESS OR INDUSTRY Laundry | |
| 13a. STATE Maryland | | 13b. COUNTY Anne Arundel | | 13c. CITY OR TOWN Dorsey | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Dailey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elvia Culver | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-16-0531 | | 17. INFORMANT Dorsey, MD. ADDRESS 21076 Mr. Louis Dailey 7131 Wright Road | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs yes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetic Mellitus, Blood vessel Type 2 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-28 19 72, to 7-9 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) see the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dr. Jose M. Yosunico | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jose M. Yosunico MD | | | | 22e. ADDRESS 612 Main Street, Laurel, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/23/82 | | 23c. NAME OF CEMETERY OR CREMATORY Saint Rest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel County, Md. | | | |
| 24. FUNERAL DIRECTOR NAME HERBERT F. NUTTER | | BALTIMORE ADDRESS MD. 21216 | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR'S SIGNATURE Frances J. Parthen | | | |



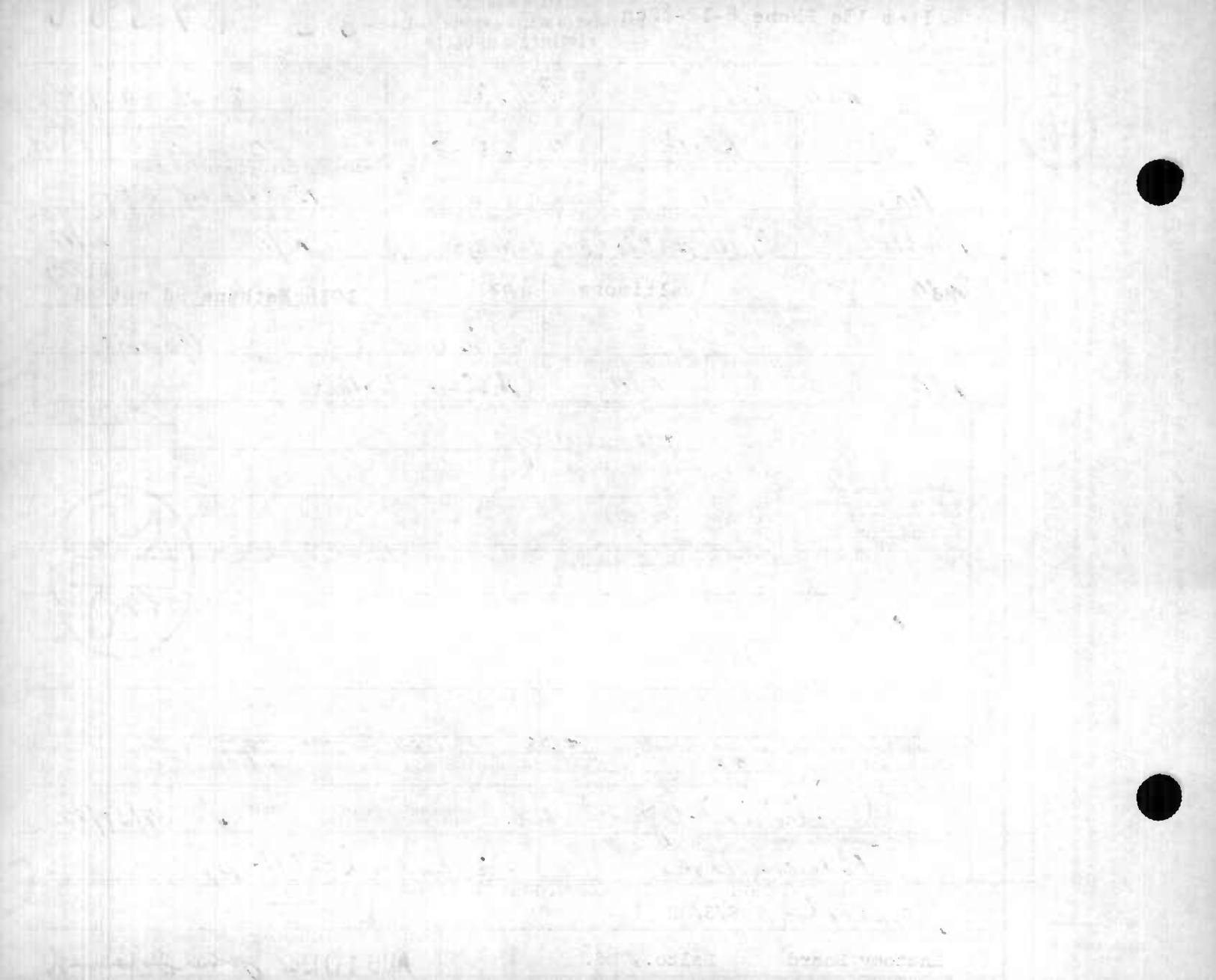
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|---|--|---|---|--|---|--|
| FOR Item 13e Phone 8-12-82en 1- STATE REGISTRAR CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Baby Girl</i> <i>Gamble</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-28-82 2b. HOUR 10 ³⁰ AM | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>Black</i> | | 5. DATE OF BIRTH MONTH DAY YEAR 7-28-82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS. 0 MONTHS 0 DAYS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. 1 17 | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Id.</i> | | 9. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 12. CITY OR TOWN OF DEATH <i>Balto.</i> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>South Balto. Gen'l Hosp</i> | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i> | | 15. KIND OF BUSINESS OR INDUSTRY <i>N/A</i> | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Baltimore</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 17. STREET ADDRESS <i>21225 1016 Bethune Rd apt A1</i> | | | | |
| 18. FATHER'S NAME FIRST MIDDLE LAST | | | | | 19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Joanne Gamble</i> | | | | |
| 20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i> | | | | | 21. SOCIAL SECURITY NO. <i>N/A</i> | | 22. INFORMANT <i>Allyce Mother</i> ADDRESS | | |
| 23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>prematurity</i> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 24. DATE OF OPERATION <i>N/A</i> | | | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 33. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 34. I certify that (I) (this hospital) attended the deceased from <i>7/28</i> , 19 <i>82</i> , to <i>7/28</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>7/28</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 35. SIGNATURE <i>Patricia Frye</i> | | | | | 36. DEGREE <i>M.D.</i> | | 37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 38. DATE SIGNED <i>7/28/82</i> |
| 39. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Patricia Frye</i> | | | | | 40. ADDRESS <i>So. Balt. Gen'l Hosp.</i> | | | | |
| 41. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i> | | | 42. DATE <i>8/5/82</i> | | 43. NAME OF CEMETERY OR CREMATORY | | 44. LOCATION CITY OR TOWN COUNTY STATE | | |
| 45. FUNERAL DIRECTOR NAME <i>Anatomy Board</i> | | | | | 46. ADDRESS <i>Balto., Md.</i> | | 47. DATE REC'D. BY REGISTRAR <i>AUG 10 1982</i> | | 48. REGISTRAR'S SIGNATURE <i>John J. Conner</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove section papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)12
1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|--|--|---|---|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert C. Garrett | | | 2a. DATE OF DEATH MONTH DAY YEAR July 3, 1982 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 12 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4515 Fairview Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Garrett | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chestanna | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 246-10-1325 | | 17. INFORMANT ADDRESS Anor Garrett 4515 Fairview Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pul Embolus 4151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/19 , 19 82 to 7/3 , 19 82 , that (I) (we) saw the deceased above or above (I) (we) saw (the doctor) view the body after death. | | | | | | |
| 22b. SIGNATURE HOWARD J. GARNER, MD | | | | 22c. DATE SIGNED 7-7-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD J. GARNER, MD | | | | 22e. ADDRESS 5310 OLD COURT ROAD | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l Mem. Pk. Laurel MD | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 8 1982 James J. Nathan | | |

MEDICAL CERTIFICATION



not all right. I am sure. S. 1008 - 1011

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and complies with the requirements of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. This certificate should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the funeral home. If the death occurred in the home, the certificate should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 0 2 | | | |
|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| STEPHEN EARL GARRETT | | | | JULY 19, 1982 | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR April 12, 1979 | | 6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Child | | 12b. KIND OF BUSINESS OR INDUSTRY n/a | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Virginia | | | | 13c. CITY OR TOWN Virginia Beach | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Larry C. Garrett | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cheryl Fishel | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Larry C. Garrett/father Same as 13 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5188 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ventricular arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) progressive interstitial pulmonary disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes 4 1/2 weeks | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: acute lymphocytic leukemia status post bone marrow transplant | | | | | | | |
| 19a. DATE OF OPERATION 6/18/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED biopsy for lung disease | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 5/2/82 to 7/19/82, that (I) (we) saw the deceased alive on 7/19/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Anne M. Murphy | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anne M Murphy | | | | 22e. ADDRESS Department Pediatrics Johns Hopkins Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 21, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Virginia Beach, Va. | |
| 24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, Va. | | | | 25. DATE REC'D. BY REGISTRAR 23 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

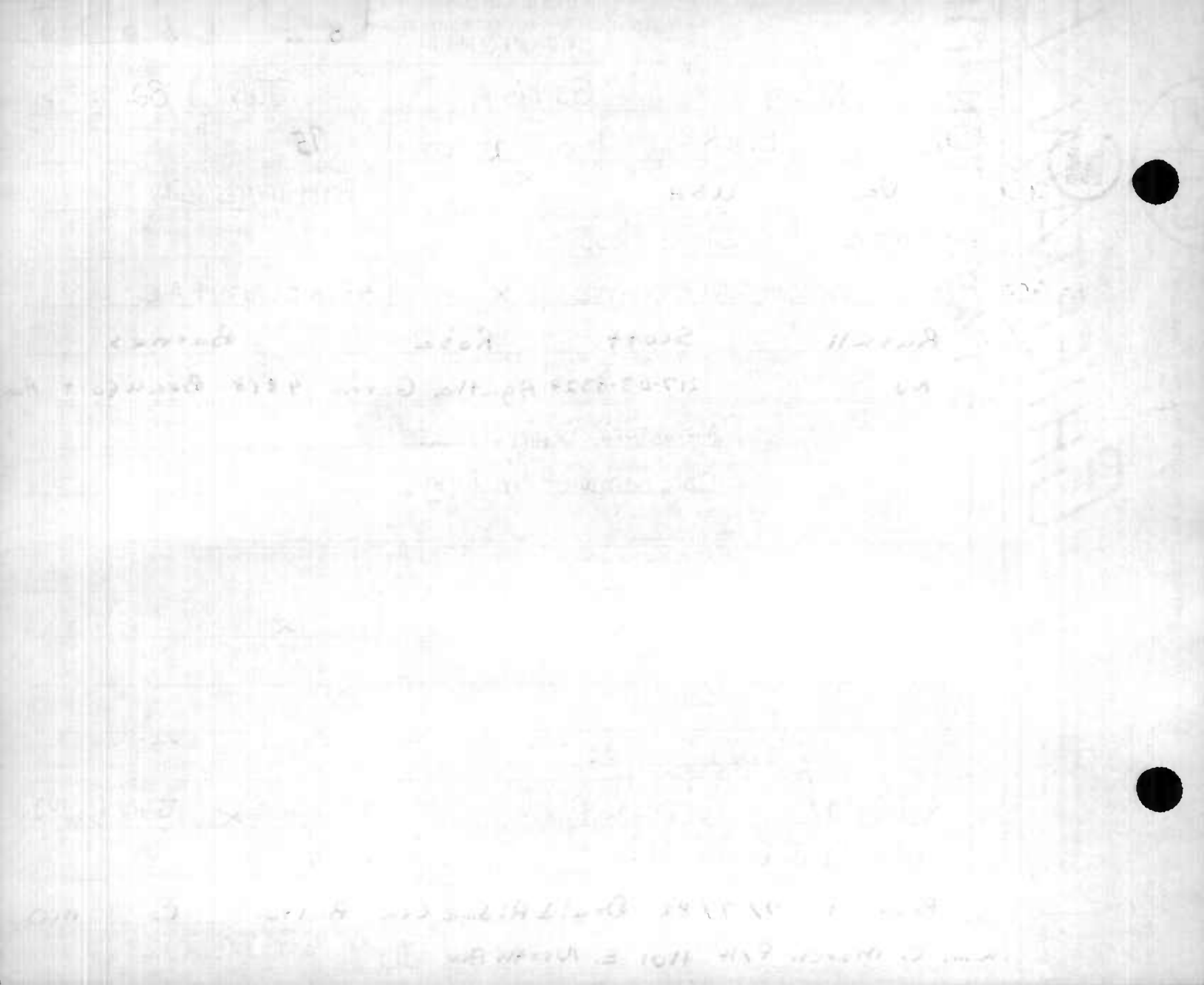
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 0 3

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) McCoy | | | 2a. DATE OF DEATH MONTH July DAY 1 YEAR 82 | | | 2b. HOUR 9:55 P.M. | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 01 DAY 22 YEAR 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | 13b. COUNTY Baltimore City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4818 Beaufort Ave | |
| 14. FATHER'S NAME FIRST Russell MIDDLE Scott LAST Scott | | | 15. MOTHER'S MAIDEN NAME FIRST Rosa MIDDLE Barnes LAST Barnes | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 217-03-8328 | |
| 17. INFORMANT Agatha Garriss | | | ADDRESS 4818 Beaufort Ave | | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Metastatic brain disease DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 82 , to July 1 , 19 82 , that (I) (we) lost saw the deceased alive on JULY 1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Deborah J. Ward M.D. | | | | | | 22c. DATE SIGNED July 1, 1982 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah J. Ward, M.D. | | |
| 22e. ADDRESS Sinai Hospital | | | | | | 22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem | | 23d. LOCATION CITY OR TOWN Balto. COUNTY Co. STATE MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 6 0 4 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) HELEN McCroskey GATES | | | | 2a. DATE OF DEATH MONTH 7 DAY 27 YEAR 82 2b. HOUR 6:28 PM | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH 4 DAY 7 YEAR 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H/W | | 12b. KIND OF BUSINESS OR INDUSTRY - | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. CITY OR TOWN BALTO 13c. CITY OR TOWN DUNDALK | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7429 HOLABIRD AVE. | |
| 14. FATHER'S NAME FIRST VICTOR MIDDLE L. LAST MCCROSKEY | | | | 15. MOTHER'S MAIDEN NAME FIRST NELLIE MIDDLE ATWOOD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 236-32-0839 | | 17. INFORMANT SYLVIA GLOVER | | ADDRESS SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension; Coronary Disease | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-27 , 19 82 , to 7-27 , 19 82 , that (I) (we) last saw the deceased alive on 7-27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Daniel M. Perlman | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-27-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL M. PERLMAN | | | | 22e. ADDRESS Baltimore City Hospi BALTO. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/30/82 | | 23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL | | 23d. LOCATION CITY OR TOWN BALTO COUNTY MD STATE MD | |
| 24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME OF DUNDALK ADDRESS | | | | 25a. DATE REC'D BY REGISTRAR AUG - 4 1982 | | 25b. REGISTRAR'S SIGNATURE James VanNathan | |

Handwritten text at the top of the page, possibly a header or title, including the word "Helen" and "1934".

Main body of handwritten text, appearing to be a letter or a journal entry, with several lines of cursive script.

Continuation of the handwritten text, showing more lines of cursive script.

Bottom section of the page with handwritten text, including what appears to be a signature or a closing phrase.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 8 2 1 7 6 0 5 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | |
| ANNA LEE GAUSEMEL | | | | | | | | 7 4 82 9:40 A.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| FEMALE | | WHITE | | 05 27 20 | | 62 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| West VIRGINIA | | USA | | | | BALTIMORE MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | LUTHERAN HOSP | | | | House duties | | Home | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Balt. City | | Baltimore | | | | 1608 Wilkins Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Edgar Clifton Castle | | Naomi Butts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 234-24-4156 | | Earl Gausemel, 1608 Wilkins Ave., Baltimore, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1809 CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA of CERVIX with METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 19 82, to July 4, 19 82, that (I) (we) lost saw the deceased alive on July 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | |
| CHENG CHUNG LIN, M.D. | | M.D. | | | | July 4, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| CHENG CHUNG LIN, M.D. | | 730 Ashburton St. Baltimore MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | July 8, 1982 | | Bethel Cemetery | | Sleepy Creek Morgan WV | | | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| BROWN F. HOME | | JUL 9 1982 | | | | [Signature] | | | |

MEDICAL CERTIFICATION

TO : SAC, NEW YORK (100-100000)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with multiple lines of text that are mostly illegible due to fading and bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Page 1 and 2 and file within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 0 6

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELLEN GEHLFUSS | | | 2a. DATE OF DEATH MONTH DAY YEAR July 24, 1982 | | 2b. HOUR 4:30pm |
| 3. SEX female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 5-14-1887 | | 6. AGE (IN YEARS LAST BIRTHDAY) 95 yrs. YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2720 Pelham Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home |
| 13a. STATE Md. | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2720 Pelham Avenue 21213 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Cornelius Toomey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 343-36-5725 | | 17. INFORMANT Harford, Conn. 06105 Clayton Dietrich 30 Woodland St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Poss sepsis - A.E.U.D. 0389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Lungs described above. | | | | | |
| 19a. DATE OF OPERATION 7/19 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 5/72 19 82 , to 7/24 19 82 , that (I) (we) lost saw the deceased alive on 7/19 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph R. Liberto | | DEGREE M.D. | | 22c. DATE SIGNED 7/26/82 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Liberto | | 22e. ADDRESS 3508 Bank Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Type) Burial | | 23b. DATE 7-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | 23e. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 27 1982 <i>James W. Nathan</i> | | | |
| 24. FUNERAL DIRECTOR NAME Shimunek Funeral Home, Inc. | | 24b. ADDRESS 3331 Brehms Lane 21213 | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17607

| | | | | | |
|--|---------|---|-------------------|--|------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Robert Michael Genna | | 7 20 19 82 | | 2:30 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Male | White | 7 5 1962 | 20 YRS. | MONTHS | DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| New York | | U. S. A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | University Hospital | | Student | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | |
| Md. | | Harford | | 21085 502 Newberry Ct. Joppa, Md. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? | |
| James | | Anna | | no | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Mr. James Genna, 502 Newberry Ct. | | PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest | | | |
| | | (b) _____ | | | |
| | | (c) _____ | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | |
| | | 12:54 P.M. 7 20 1982 | | Subject shot | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | home | | 502 Newberry Ct. Joppa | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Ann M. Dixon, M.D. | | M.D. Assistant | | 7/21/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | DATE REC'D. BY REGISTRAR | |
| | | 111 Penn St. Balto., MD. | | 27 1982 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 7-24-1982 | | Bel Air Mem. Gardens | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| E.F. Lassam, 11750 Belair Rd. Kingsville, Md. 21087 | | 27 1982 | | James J. Keith | |

OFFICE
OF THE
TREASURER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 6 0 8 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT B. GEORGE | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 29 82 | | 2b. HOUR 7:33 AM | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 14, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARried <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 15. KIND OF BUSINESS OR INDUSTRY Food | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 201 Dumbarton Road | | | | | | | | | |
| 17. FATHER'S NAME FIRST MIDDLE LAST Ira R. George | | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle M. Patterson | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I | | 20. INFORMANT ADDRESS Mrs. Marie W. George 201 Dumbarton Rd. | | | | | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4416 IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) ruptured aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Aplastic Anemia, respiratory failure, old myocardial infarct | | | | | | | | | |
| 22a. DATE OF OPERATION None | | 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 23b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 26. I certify that (I) (this hospital) attended the deceased from 6/30 1982, to 7/29 1982, that (we) last saw the deceased alive on 7/29 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death. | | | | | | | | | |
| 27. SIGNATURE David Leichtling | | | | 28. DEGREE MD | | 29. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 30. DATE SIGNED 7/29/82 | |
| 31. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID LEICHTLING, M.D. | | | | 32. ADDRESS 201 E. UNIVERSITY PARKWAY | | | | | |
| 33a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 33b. DATE 8/2/82 | | 33c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 33d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 34. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC. | | | | 34. ADDRESS 6500 York Rd. | | 35. DATE REC'D. BY REGISTRAR AUG 4 1982 | | 36. REGISTRAR'S SIGNATURE Anne J. [Signature] | |

Dec. 14, 1937

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 6 0 9 | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian E. GERBIG | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 82 | | | 2b. HOUR 3:40 AM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 4 6 96 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2608 Southern Avenue-212 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Beck | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Kammerel | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-05-49430 | | 17. INFORMANT ADDRESS Mrs. Elizabeth L. Kipe -2608 Southern Ave. 21214 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Adel S. El-Hennawy | | | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADEL S. EL-HENNAWY | | | | | | 22e. ADDRESS GSH. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE - Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | 25. DATE RECD. BY REGISTRAR 7/21/1982 | | REGISTRAR'S SIGNATURE James J. Nathan | | | |

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 1 0

REG. NO.

| | | | | | | | |
|--|--|--|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| CHARLES | | Alvin | | GERMAN, Sr. | | 7 3 82 7:12 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR May 26, 1903 | | 79 YRS. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | U.S.A. | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | St. Agnes Hospital | | Salesman | | F.A. Davis & | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | Baltimore | Baltimore | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 830 Braeside Rd. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | |
| Charles S. German | | Lillie Slade | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 215-07-6075 | | Charles Alvin German, Jr. - Same as Sec. 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Coagulopathy | | | | | | | 30 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) massive blood transfusion | | | | | | | 36 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardiorespiratory arrest | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| Pulmonary failure; renal failure | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 7/2/82 | | Abdominal aneurysm | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION (CITY OR TOWN COUNTY STATE) | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/1/82 to 7/3/82, that (I) (we) lost saw the deceased alive on 7/3/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | |
| David McFadden | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| DR. MCFADDEN | | 532 A N. Bond St Balt, MD 21205 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (CITY OR TOWN COUNTY STATE) | |
| Burial | | July 7, 1982 | | Woodlawn Cemetery | | Woodlawn Baltimore MD. | |
| 24. FUNERAL DIRECTOR (NAME ADDRESS) | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leta M. & Russell C. Witzke Funeral Home P.A. 1630 Edmondson Ave., Catonsville, MD. 21228 | | | | JUL 8 1982 | | James VanNathan | |

TO THE HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
JAN 12 1932

Dear Sirs:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the proposed amendment to the National Firearms Act, 1934, and in reply to inform you that the same has been referred to the Committee on Education and Labor, and that the Committee is currently studying the same.

I am, Sir, very respectfully,
Yours very truly,
J. P. Cullen

JOHN P. CULLEN
Chairman, Committee on Education and Labor
U. S. HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

Enclosed for you are two copies of a report of the Committee on Education and Labor, dated January 10, 1932, in relation to the proposed amendment to the National Firearms Act, 1934, and in reply to inform you that the same has been referred to the Committee on Education and Labor, and that the Committee is currently studying the same.

Very truly,
J. P. Cullen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be consulted at office.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 1 1

REG. NO.

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|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON GERMAN | | MONTH DAY YEAR 7 28 82 | | 6:45A M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 5 6 15 | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | 7b. CITIZEN OF WHAT COUNTRY? USA. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VAMC LOCH RAVEN BALTO. MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 716 N. Collington | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elliott German | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Williams | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 217 09 8950 | 17. INFORMANT ADDRESS Emiley German 716 N. Collington | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Oat Cell Carcinoma Lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>5 days</u> <u>2 months</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Granulocytopenia Pneumonia</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>June 21</u> , 19 <u>82</u> , to <u>July 28</u> , 19 <u>82</u> , that <u>X</u> (we) last saw the deceased alive on <u>July 28</u> , 19 <u>82</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kevin Doyle MD | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin Doyle | | 22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 8/2/82 | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue | | 25a. DATE REC'D-BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Santhron | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

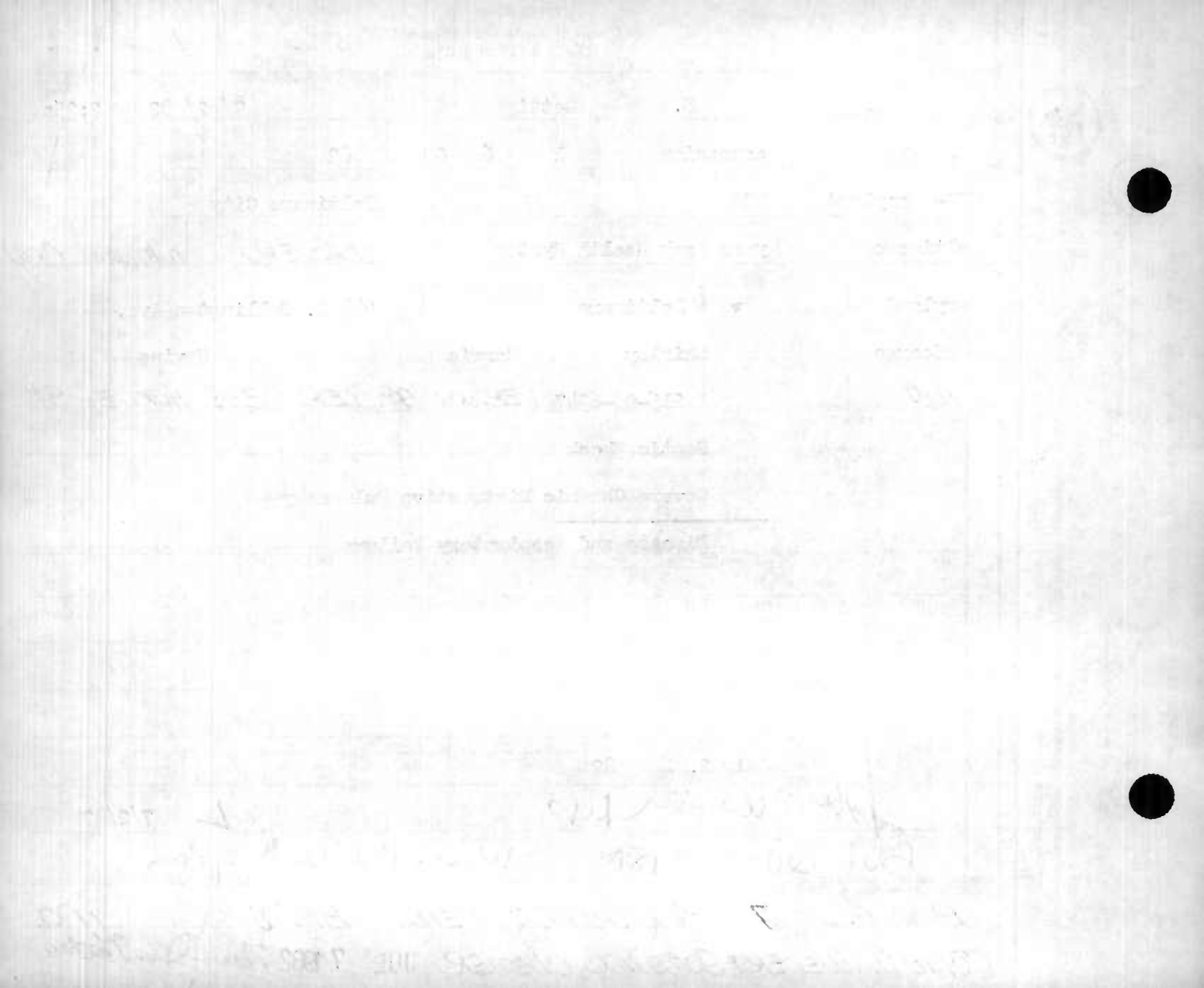
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 1 2
REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara E. Gettig | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/ 2/ 82 | | 2b. HOUR 2:25a.m |
| 3. SEX Female | 4. RACE caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 1 6 00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA- Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wyman Park Health System | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY NATIONAL CAR |
| 13a. STATE Maryland | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Shipley | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Hovino | | 13e. STREET ADDRESS 241 S. Collington Ave. | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-09-6347 | | 17. INFORMANT ADDRESS VERDON BAKER 338 HORDEL ST | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Destructive Pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) Disease and Respiratory Failure | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on July 2, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Dr. Quoc Cron | | DEGREE | | 22c. DATE SIGNED 7/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR QUOC CRON | | 22e. ADDRESS Wyman Park Health System | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-6-82 | | 23c. NAME OF CEMETERY OR CREMATORY SWARTZ CEM | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE John M. Weber & Sons Inc. CHESTER JUL 7 1982 Phyllis VanNathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the time of disinterment, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 6 1 3 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR |
| STEVEN D GHEE | | | | | JULY 5, 1982 | | | | 1:22p |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| Male | | Black | | MONTH DAY YEAR 6 7 50 | | 32 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MD | | USA | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | JOHNS HOPKINS HOSPITAL | | | | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? |
| MD | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Claborne | | | | | FIRST MIDDLE LAST Ida Jones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | 217-52-6982 | | Ida Ghee 702 Beaumont Ave. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> | | | | | | | | 5y+1 | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> | | | | | | | | 5y+1 | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Edema acute</u> | | | | | | | | 10y+1 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/82</u> , 19 <u>82</u> , to <u>7/5</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/1</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Phil Buesche</u> | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/5/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| Phil Buesche | | | | | | J.H.H. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 7/8/82 | | St. Luke's Cem. | | Baltimore Co. MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | JUL 6 1982 <u>James J. Martin</u> | | | |

MEDICAL CERTIFICATION

RECEIVED

RECEIVED

RECEIVED



RECEIVED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

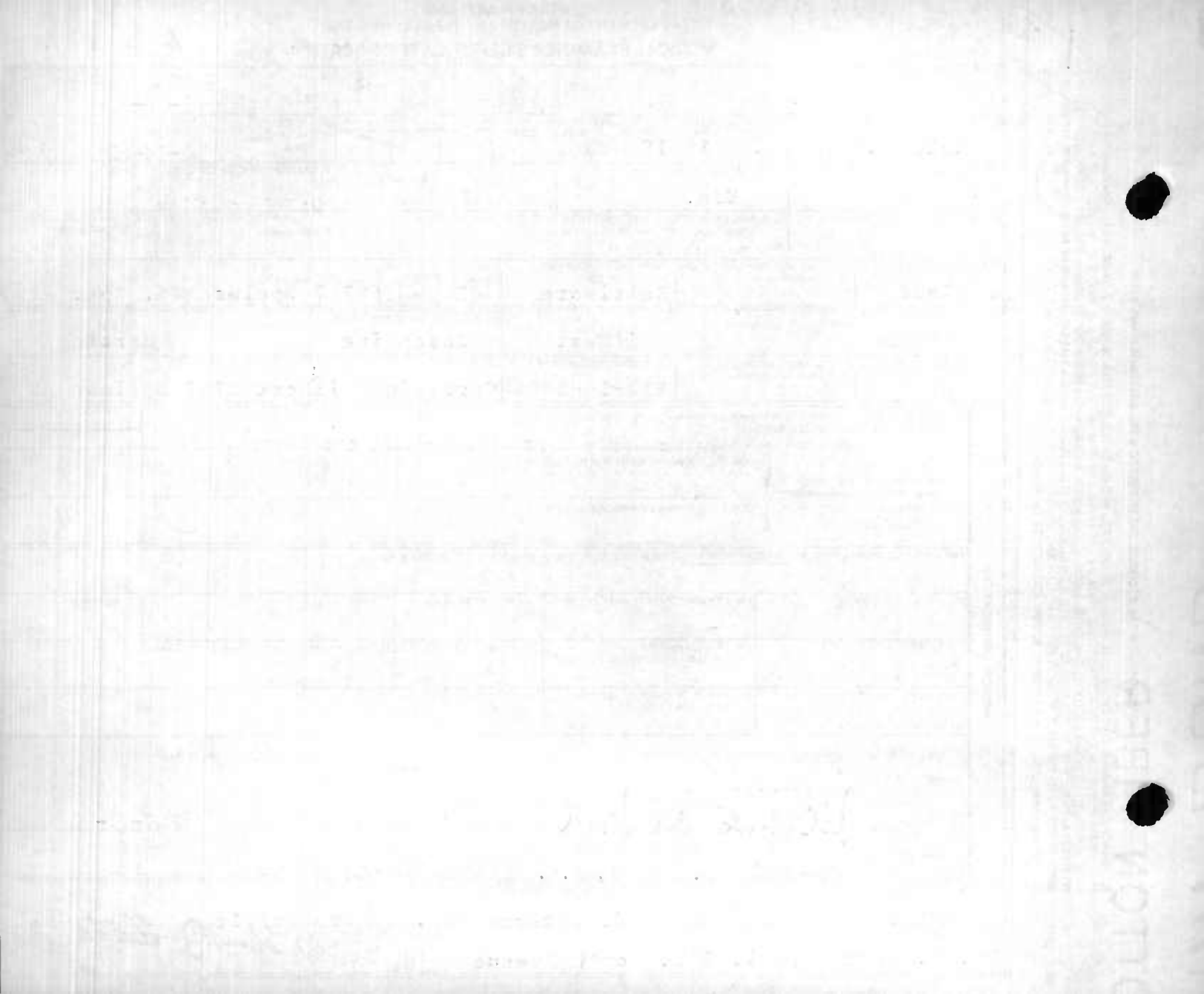
REG. NO.

17614

| | | | | | | | | | | | | | | | | | | | |
|---|---------|---|--|---|--|---|--|--------------------------------------|--|--|--|---------|--|-----|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| JACK | | E. | | GILBERT | | | | 7-26-82 | | | | 7-26-82 | | | | | | 4:50P | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Male | Black | 8 19 18 | | 63 YRS. | | | | | | 7-26-82 | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Virginia | | USA. | | WIDOWED | | DIVORCED | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 2707 Spellman 2A | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2707 Spelman Rd. Apt. A2 | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Abraham | | Gilbert | | Josephine | | Martin | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| Yes | | 213-16-3694 | | Geraldine Gilbert | | 2707 Spelman A2 | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular | | | | | | | | | | | | | | | | | | | |
| 4029 | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) disease | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input type="checkbox"/> | | Inspection <input checked="" type="checkbox"/> | | Inquiry <input type="checkbox"/> | | and in my opinion | | | | | | | | | | | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> | | Accident <input type="checkbox"/> | | Suicide <input type="checkbox"/> | | Homicide <input type="checkbox"/> | | Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Margarita A. Koroll, M.D. | | M.D. Assistant | | 7-27-82 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | |
| Margarita A. Koroll, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY | | STATE | | | | | | | | | |
| BURIAL | | 8/2/82 | | Md. Veteran Cem. | | Crownville | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | REG. IN | | | | | | | | | | | |
| Wm. C. March F/H 1101 E. North Avenue | | | | | | JUL 28 1982 | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGES 5 THROUGH 10 FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 1 5

REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | |
| DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER GILL | | | JULY 22, 1982 | | | 9:30 A M | | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10-29-1916 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 65 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2414 E. Fairmont Ave.-21224 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Joseph R. Rdein | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Landis | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | |
| 16b. 214-18-6318 218-26-2091 | | | 17. INFORMANT ADDRESS Charles E. Gill 3202 N. Country Club Rd. | | | 18. 85719 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypovolemic Shock 1844 DUE TO, OR AS A CONSEQUENCE OF (b) anterior & posterior pelvic exenteration DUE TO, OR AS A CONSEQUENCE OF (c) Infiltrating carcinoma of vulva | | | | | | | | | 4 hr. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION 7-20-81 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Infiltrating squamous cancer | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-29 19 82 , to 7-22 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-22 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE J Rice MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J Rice | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-24-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | |
| 24 FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | |

MEDICAL CERTIFICATION

9 9

0602 BP

John. Robert.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 1 6

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MORRIS W GILL | | | 2a. DATE OF DEATH MONTH 7 DAY 3 YEAR 82 2b. HOUR 6:00 AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH June 19 DAY 19 YEAR 1906 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello State Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman | | | 12b. KIND OF BUSINESS OR INDUSTRY Balti. City | | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | |
| 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST William MIDDLE Gill LAST Gill | | | 15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Lockstamper LAST Lockstamper | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 216 10 1798A | | 17. INFORMANT ADDRESS Shelda D. Gill 3436 Roland Ave. 21211 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4360 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA, DIABETES CORONARY ARTERY disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3 19 82 saw the deceased alive on 7/3 19 82 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign the body after death. | | | | | |
| 22b. SIGNATURE Jose Portuonix | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE PORTUONIX | | 22e. ADDRESS Montebello State Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 6 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | |
| 23d. LOCATION CITY OR TOWN Parkville COUNTY Baltimore STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Burgee Funeral Home | | ADDRESS 3631 Falls Rd. Balti. | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. North | |

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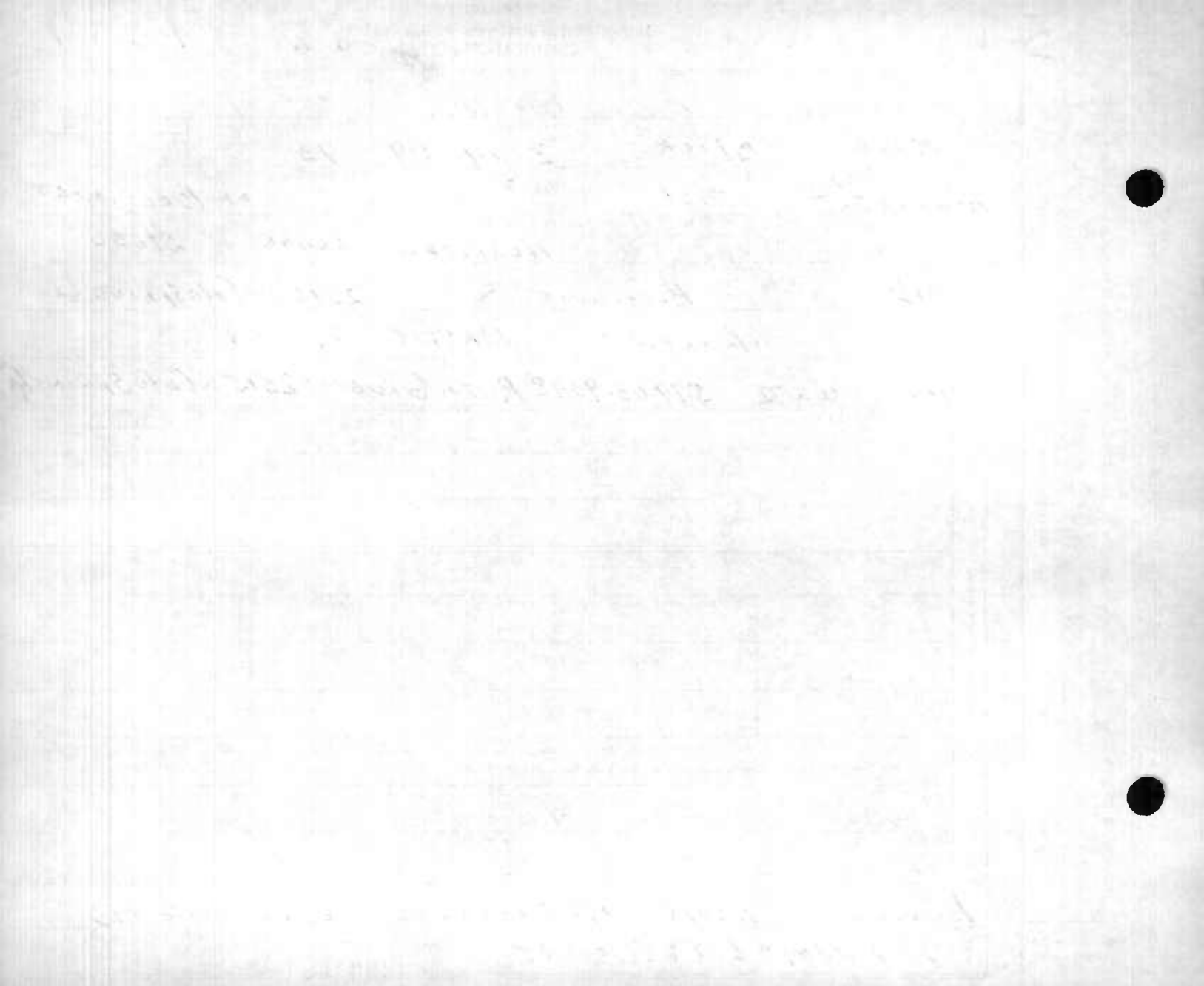
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
|--|--|--|--|---------------------------|--|--|--|--|--|---------------------------------|--|---------------------------------------|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. DATE OF DEATH | | 8. HOUR | |
| | | CHARLES M GIVENS | | MALE | | BLACK | | 3 14 09 | | 73 | | 7 16 82 | | 3 AM | |
| | | 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 13. KIND OF BUSINESS OR | | 14. BALTIMORE CITY OR COUNTY OF DEATH | | 15. STREET ADDRESS | |
| | | HOWARD CO. MD. | | BALTIMORE | | PROVIDENT HOSPITAL | | LABORER | | STEEL | | CITY OF BALTIMORE MD. | | 2515 W COLDSPLAIN LA | |
| | | 16. FATHER'S NAME | | 17. MOTHER'S MAIDEN NAME | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | 19. SOCIAL SECURITY NO. | | 20. INFORMANT | | 21. DATE OF OPERATION | | 22. DATE SIGNED | |
| | | UNKNOWN | | HARRIE GIVENS | | 7991 | | 579-03-9048 | | RUTH GIVENS | | 9 | | 7-16-82 | |
| | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 13f. DATE OF OPERATION | | 13g. DATE SIGNED | |
| | | MD | | BALTIMORE | | BALTIMORE | | YES | | 2515 W COLDSPLAIN LA | | 9 | | 7-16-82 | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|---|---|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| FOR 1. STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) PRICE HUTCHINS GLADDEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 10 82 | | | | | 2b. HOUR 405 P.M. |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 18, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent | | 12b. KIND OF BUSINESS OR INDUSTRY Welsh Const. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abel Gladden | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 213 10 2459 | | 17. INFORMANT ADDRESS Mrs. Hazel B. Gladden, Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MALNUTRITION</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC RENAL FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>CHRONIC CONGESTIVE HEART FAILURE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Chronic Lymphocytic Leukemia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19, 1982</u> to <u>JULY 10, 1982</u> , that (I) (we) lost saw the deceased alive on <u>JULY 10, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE <u>Carl Sperling M.D.</u> | | | | | DEGREE MD | | | 22c. DATE SIGNED 7/10/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLING, M.D. | | | | | 22e. ADDRESS 201 E. UNIVERSITY PKWY BALTO 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/13/82 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Co. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road, Balto., Md. 21212 | | | | | 25a. DATE REG'D BY REGISTRAR JUL 12 1982 | | | | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan |

13
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS OCCUR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

FOR Items #18a-22a Film G591 9/8/82 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 1 7 6 1 9 REG. NO.

| | | | | |
|--|-------------------------------------|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Vicky L. Gobble | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 9 1982 | | 2b. HOUR M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1960 22 YRS. | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7 10 1982 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2923 Christopher Avenue | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife |
| 13a. STATE Md. | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Carroll Robert Linck | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Doris Smoot | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 219-62-3259 | | 17. INFORMANT ADDRESS North East, Md. Mr. William O. Campion Jr. 180 Walton La. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate overdose</u> 9501 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/?/ 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/ingested |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2923 Christopher Ave. Baltimore Md. |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Margarita A. Korell, M.D. | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | DATE SIGNED 7-11-82 |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 111 Penn Street | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE July 14, 1982 | 23c. NAME OF CEMETERY OR CREMATORY Mt Carmel | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE Frances J. Nathan |

Walter A. S. S. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 2 0 | | | |
|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| STEPHEN H. GODFREY | | | | 7-14-82 2:54 PM | | | |
| 3. SEX M | | 4. RACE BLACK | | 5. DATE OF BIRTH 4-12-20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) City Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 2541 Greenmount Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stephen H. Godfrey Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Davis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] Yes | | | | 16b. SOCIAL SECURITY NO. 231-01-6729 | | 17. INFORMANT Stephanie Staton 3005 Glen Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cat cell lung CANCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 is |
| 19a. DATE OF OPERATION / | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED / | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE MARVIN J. VOLLMER M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) VOLLMER, MARVIN | | | | 22e. ADDRESS % Baltimore City Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Nolfork VA | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 6 2 1 | |
|--|--|--|---|---|--|---|---|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Abraham Goldberg</u> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>7-18-82</u> | | | 2b. HOUR <u>7:24 A.</u> M | | | |
| 3. SEX <u>M</u> A F E | | 4. RACE <u>W</u> H I T E | | 5. DATE OF BIRTH MONTH DAY YEAR <u>6 2 1907</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore</u> CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital</u> | | | | 12a. USUAL OCCUPATION (MOST OF WORKING LIFE) <u>SALESMAN</u> <u>retired</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE</u> | | | |
| 13a. STATE <u>Maryland</u> | | 13b. COUNTY <u>Baltimore</u> | | 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>MILLBROOK APTS. 21215</u> <u>APT. 1-D</u> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>MORRIS PHILIP GOLDBERG</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE <u>ANNA ROSENBERG</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u> | | | | | 16b. SOCIAL SECURITY NO. <u>215-32-8368</u> | | 17. INFORMANT ADDRESS <u>MRS. MELVIN R. SWEREN</u> <u>110 E. LEXINGTON ST.</u> <u>SIUTE 204 21202</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <u>4100</u> IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>7-18</u> P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>82</u> , to <u>7-18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>G. Giliam 9153</u> | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <u>7/18/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. Giliam 9153</u> | | | | | 22e. ADDRESS <u>SINAI HOSPITAL</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | | 23b. DATE <u>JULY 19, 1982</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE</u> <u>MARYLAND</u> | | | | |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</u> | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 REGISTRAR'S SIGNATURE <u>James Dan Nathan</u> | | | | | |

17

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31-5

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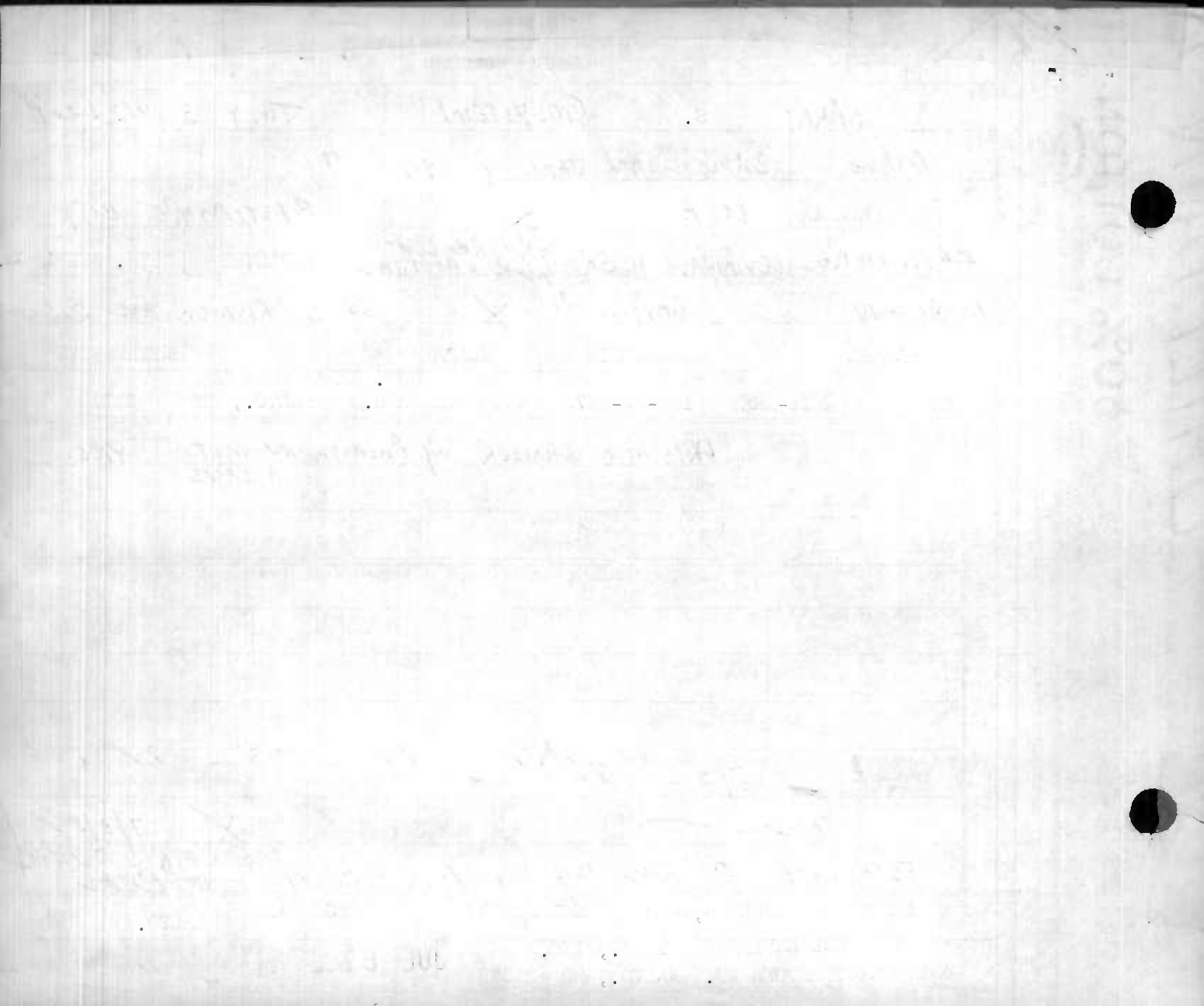
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 2 2

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|---|---|---|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) HARRY S. GOLDSTEIN | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 3 1982 | | | 2b. HOUR 1:20 P.M. | |
| 3. SEX MALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 6 1911 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 71 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GERIATRIC CENTER + HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EMPLOYEE | | 12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL CO. | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL GOLDSTEIN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA HERSHKOVITS | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII-ARMY | | | |
| 17. SOCIAL SECURITY NO. 192-09-1279 | | 18. INFORMANT MRS. SARAH GOLDMAN | | 4000 GLEN AVE. BALTO., MD | | 21215 | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATIC CANCER w/ PULMONARY MET-ASTASIS 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/27 , 19 82 , to 7/3 , 19 82 , that (we) last saw the deceased alive on 7/3 , 19 82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELLITA O. KNU, M.D. | | 22e. ADDRESS GERIATRIC CENTER + HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 5, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ANSHE NEISEN | | 23d. LOCATION ROSEDALE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25. DATE REC'D. BY REGISTRAR JUL 8 1982 | | | |
| | | | | 26. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 2 3 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST CLYDE M GOODWIN | | | | MONTH DAY YEAR HOUR JULY 25 1982 2:50AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | MONTH DAY YEAR 10 13 1929 | | 52 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | JOHNS HOPKINS HOSPITAL | | Upholsterer | | | |
| 13a. STATE | | | | 13b. STREET ADDRESS | | | |
| Maryland | | | | 2967 Yorkway | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| Benjamin C. Goodwin | | | | Sophie M. Berends | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | |
| Yes | | | | 1957-1977 | | 2967 Yorkway Balto., MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) REFRACTORY VENTRICULAR TACHYCARDIA TO VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR. 1 HR. 15 YR. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 7-22-82 | | CORONARY ARTERY DISEASE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-22, 19 82, to 7-25, 19 82, that (I) (we) lost saw the deceased alive on 7-25, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard Scott Stuart MD | | | | 22c. DATE SIGNED 7-25-82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD SCOTT STUART MD | |
| 22e. ADDRESS JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTO. MD. 21205 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/28/1982 | | Crownsville | | Crownsville Maryland | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

REPORT OF SPECIAL AGENT IN CHARGE

TO DIRECTOR, FBI

FROM SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

DATE: [Illegible]
BY: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 2 4 | | | |
|---|--|---|--|---|--|--|---|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) EDWARD Davis GORDON | | | | 2a. DATE OF DEATH MONTH- DAY YEAR July 2, 1982 | | 2b. HOUR 8:10a | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 12 7 21 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fredrick Gordon | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Maxine Woods 2021 Woodburn Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable hypertension 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Menigeitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 8 hours. | | | | | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Laryngeal Cancer in |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 82 , to 7/2 , 19 82 ; that (I) (we) lost saw the deceased alive on 7/2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE D. Hockenbery | | | | DEGREE MO | | 22c. DATE SIGNED 7/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Hockenbery MD | | | | 22e. ADDRESS 601 N. Wolfe St. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md | |
| 24. FUNERAL DIRECTOR NAME ADDRESS BETTS F/H 1129 N. Caroline St | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | |

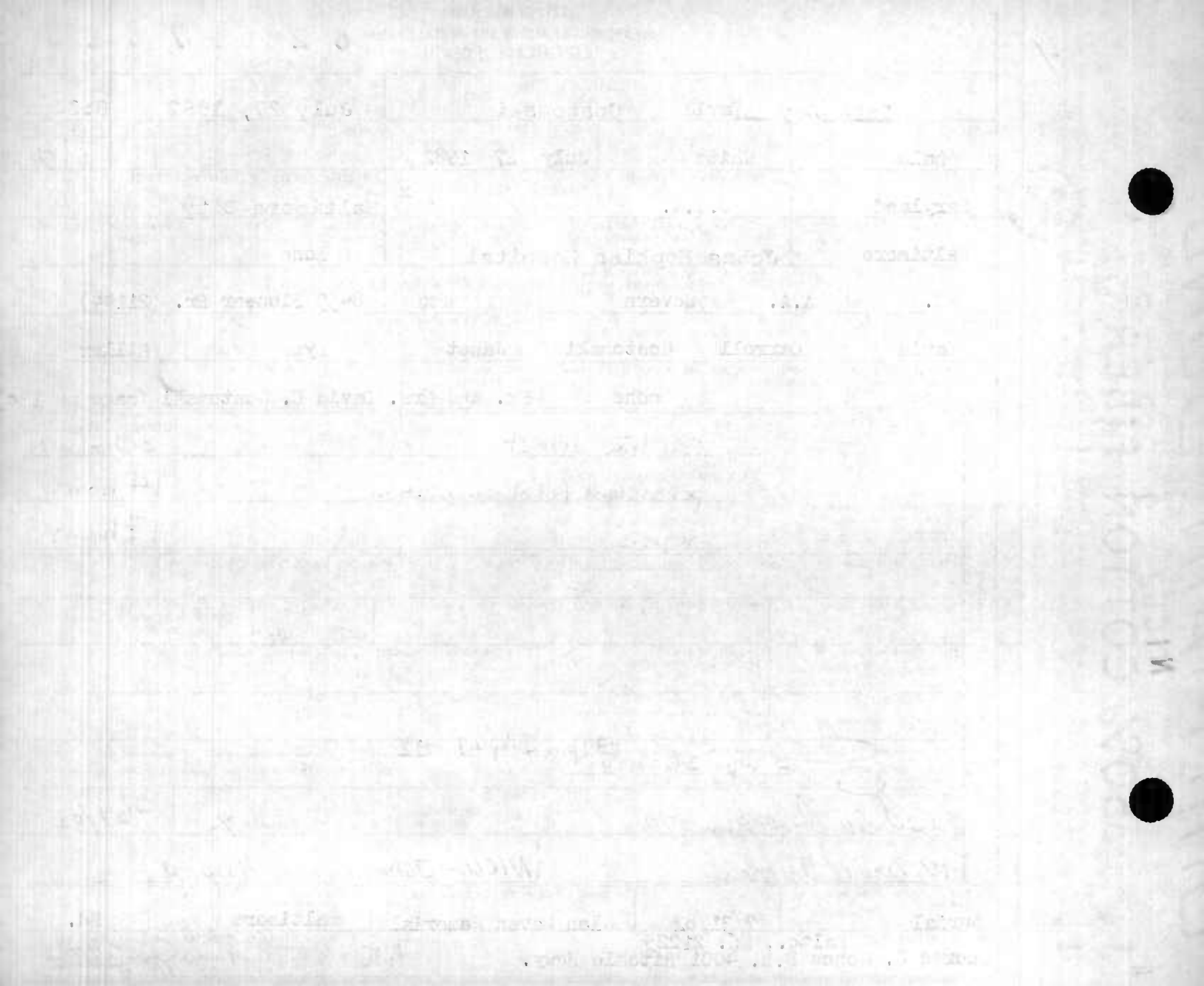


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Their please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified or one

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 8 2 1 7 6 2 5 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Carroll David Gostomski | | | 2a. DATE OF DEATH July 27, 1982 | | | 2b. HOUR 8:34pm | | | |
| 1. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 27 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 6 34 | | 8. IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Severn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 8453 Pioneer Dr. (21144) | |
| 14. FATHER'S NAME FIRST MIDDLE LAST David Carroll Gostomski | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Lynn Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mr. and Mrs. David C. Gostomski (same as 13e) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 74779 IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) persistent fetal circulation DUE TO, OR AS A CONSEQUENCE OF (c) sepsis DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 14 hours 17 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2:39 pm July 27 1982 , to 8:34 pm July 27 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE W. Daniel Jackson MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Daniel Jackson | | | | 22e. ADDRESS NICU - Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Balto., Md. 21225 George J. Gonce F.H. 4001 Ritchie Hwy. | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | |



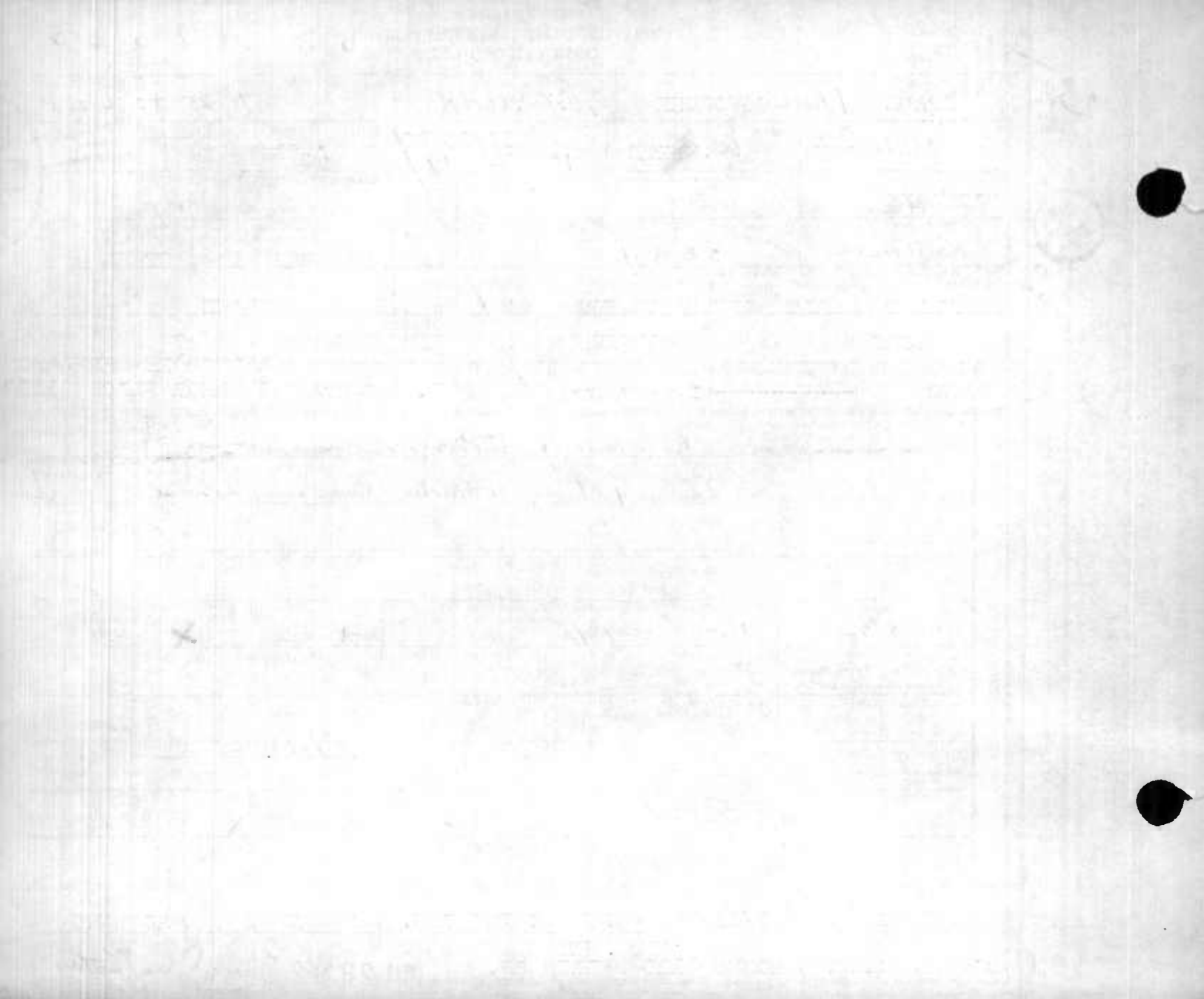
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 6 2 6 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) PAUL PAUL GOVORUHK GOVORUHK | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 25 82 | | 2b. HOUR 4:20 A.M. | | | |
| 3 SEX Male MALE | | 4 RACE W. WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10 16 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SB & H | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY STEEL | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3 MANOR PLACE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACOB GOVORUHK | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EFROSINA ? | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 218-07-1226 | | 17. INFORMANT ADDRESS BERTHA L. GOVORUHK 3 MANOR PLACE 21237 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Advanced Chronic obstructive Pulmonary disease</u> | | | | | | | | many years | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION 6/25/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bronchoscopy | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/24/82</u> , 19 <u>82</u> , to <u>7/25/82</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/25/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/25/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Attending Benjamin M.D. | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/29/1982 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY TRINITY CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME DIPPEL FUNERAL HOMES 7110 BELAIR RD. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 28 1982 <u>[Signature]</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 6 2 7 | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHIRLEY G. GRADDICK | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 12, 1982 | | 2b. HOUR 3:57a | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9 3 1937 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook-Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY Laskey's | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Edgemere | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2525 Snyder Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Earl Stark | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Grace Warnick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No | | 16b. SOCIAL SECURITY NO. 163-30-7318 | | 17. INFORMANT Nathan J. Graddick | | ADDRESS: 2525 Snyder Ave. Balto., MD. 21219 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the breast, widely metastatic DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION NA | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) NA | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-7 , 19 82 , to 7-12 , 19 82 , that (I) (we) last saw the deceased alive on 7-12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Joseph S. Weinstein | | | | DEGREE MD | | 22c. DATE SIGNED 7-12-82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph S. Weinstein | | | | 22e. ADDRESS 550 N. Broadway Apt. 902 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/15/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE Charles J. VanNathan | | | |

Σ=52, CI=95%

.51

YITC 2014

DATE: 11/11/2011 TIME: 11:11

Abstract

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17628

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) SAMUEL DAVID GRADY | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-1-82 19 | | 2b. HOUR 10:05A |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1958 | 6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-1-82 19 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) S.T.U. University Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | |
| 13a. STATE N.C. | | 13b. COUNTY | | 13c. CITY OR TOWN Albertson | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jack Donald Grady | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Korney | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | |
| 16b. SOCIAL SECURITY NO. 240 78 7600 | | 17. INFORMANT ADDRESS Pink Hill Funeral Home | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8149 IMMEDIATE CAUSE (a) Cranio-cerebral injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY MONTH DAY YEAR 8:56AM 7-1-82 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was run over by tractor trailer | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Loading dock at | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. Produce Market Jessup, Maryland | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Margie M. Hall | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 7-1-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D. | | ADDRESS 111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE 7/3/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oakridge Memorial Park | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Pink Hill, North Carolina | | 24. FUNERAL DIRECTOR Burgee Funeral Home | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | |
| 3631 Falls Road Baltimore, Md. 21211 | | 25b. REGISTRAR'S SIGNATURE Name | | | |

DATE: 11/11/51

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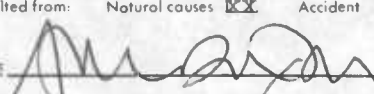
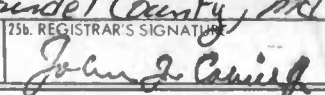
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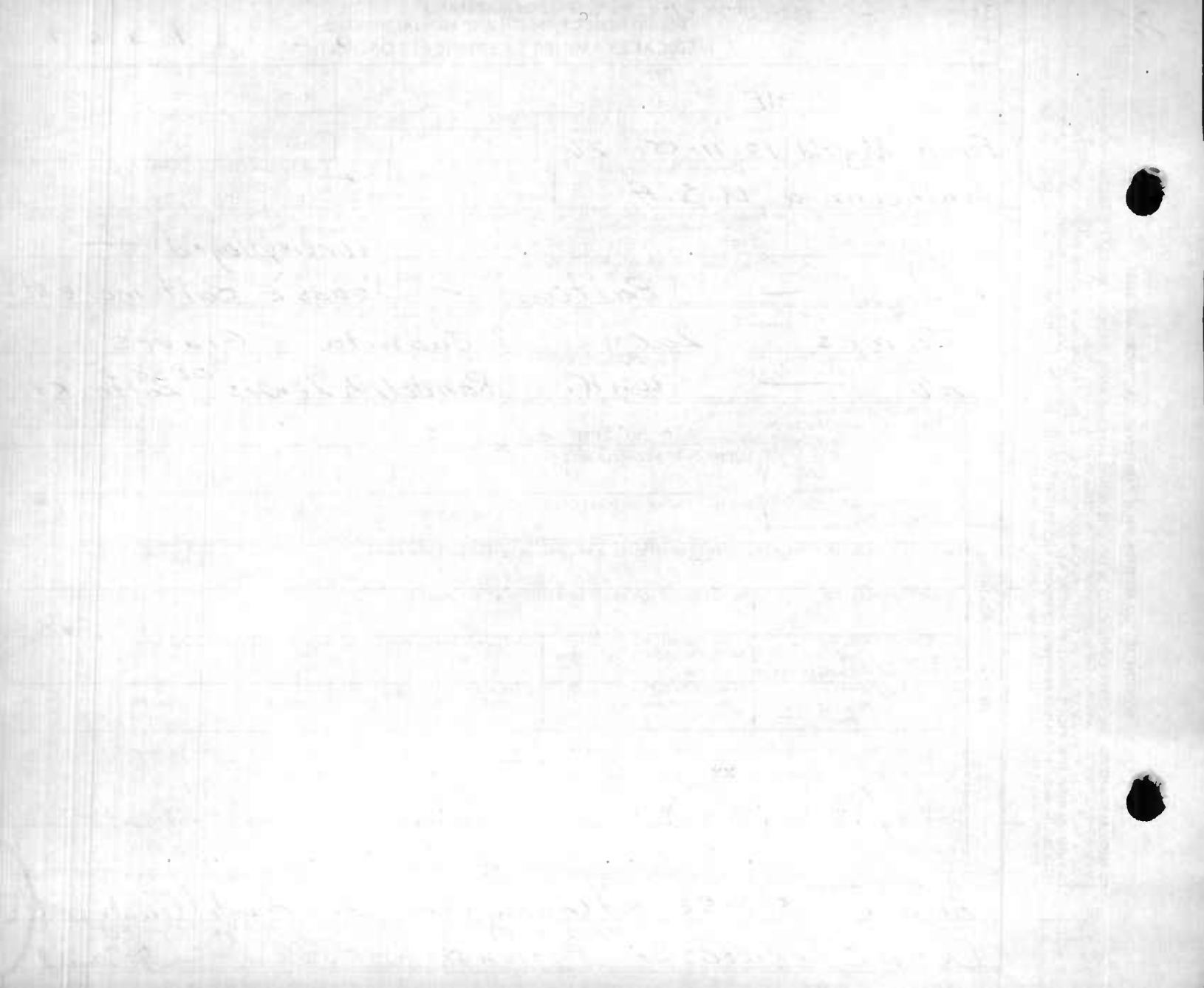
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24-HOUR FILE AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17629 | |
|--|---------------------------|--|---|---|--|---|--|--|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FRENCHIE D. GRAVES | | | | | | 2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 7 31 19 82 | | | 2b. HOUR 12:55 a.m. | | |
| 3. SEX Female | 4. RACE Negroid | 5. DATE OF BIRTH MONTH 12 DAY 11 YEAR 55 | 6. AGE (IN YEARS) LAST BIRTHDAY 26 YRS. | IF UNDER 1 YR. MONTHS 26 DAYS 26 HOURS 26 MIN. | IF UNDER 24 HRS. HOURS 26 MIN. | 2c. DATE PRONOUNCED DEAD MONTH 8 DAY 1 YEAR 19 82 | | | 2d. HOUR 12:55 a.m. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2038 E. Baltimore St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY — | | | |
| 13a. STATE Md. | | 13b. COUNTY — | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2038 E. Baltimore St. | | | |
| 14. FATHER'S NAME FIRST James MIDDLE Lacy LAST Lacy | | | | 15. MOTHER'S MAIDEN NAME FIRST Juanita MIDDLE Graves LAST Graves | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unk. | | 17. INFORMANT ADDRESS Randolph Lewis 2038 E. Balto. St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alcoholism 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) — (c) — DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 8-1-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-7-82 | | 23c. NAME OF CEMETERY OR CREMATORY mt. Calvary Cem. | | | | 23d. LOCATION CITY OR TOWN Anne Arundel County, Md. COUNTY — STATE — | | | |
| 24. FUNERAL DIRECTOR NAME Calvin B. Scruggs Sr. ADDRESS 1412 E. Preston St. | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 5 1982 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

BP

DHMH - 17
VR A15 ME (5)
20M 4/82



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 3 0

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---------------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Henry | | MIDDLE J. | | LAST Gredlein | | 2a. DATE OF DEATH | | MONTH 7 | | DAY 15 | | YEAR 82 | | 2b. HOUR 8:30 | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH | | MONTH Oct | | DAY 29 | | YEAR 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 | | YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | MD. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) photography | | 12b. KIND OF BUSINESS OR INDUSTRY self | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Halethorpe | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1020 Downton Road | | | | | |
| 14. FATHER'S NAME FIRST Peter Gredlein | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME FIRST Margaret VonDrän | | MIDDLE | | LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 216-05-1313 | | 17. INFORMANT Garry Gredlein | |
| 16c. ADDRESS 114 Greenbriar Rd. | | | | | | 29646 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure secondary to</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive pulmonary disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> , 19 <u>82</u> , to <u>7-15</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>M. H. W.</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/15/82 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 900 Calton Ave, St Agnes Hospital Baltimore | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation | | 23b. DATE 7/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Westview Crematory | | 23d. LOCATION CITY OR TOWN Gtonville | | COUNTY Balto. | | STATE Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Ambrose Funeral Home | | ADDRESS 1328 Sulphur Spring Rd | | 25a. DATE OF REGISTRATION 7/16/82 | | 25b. SIGNATURE [Signature] | | | | | | | | | | | |

11

11-11-11

11-11-11



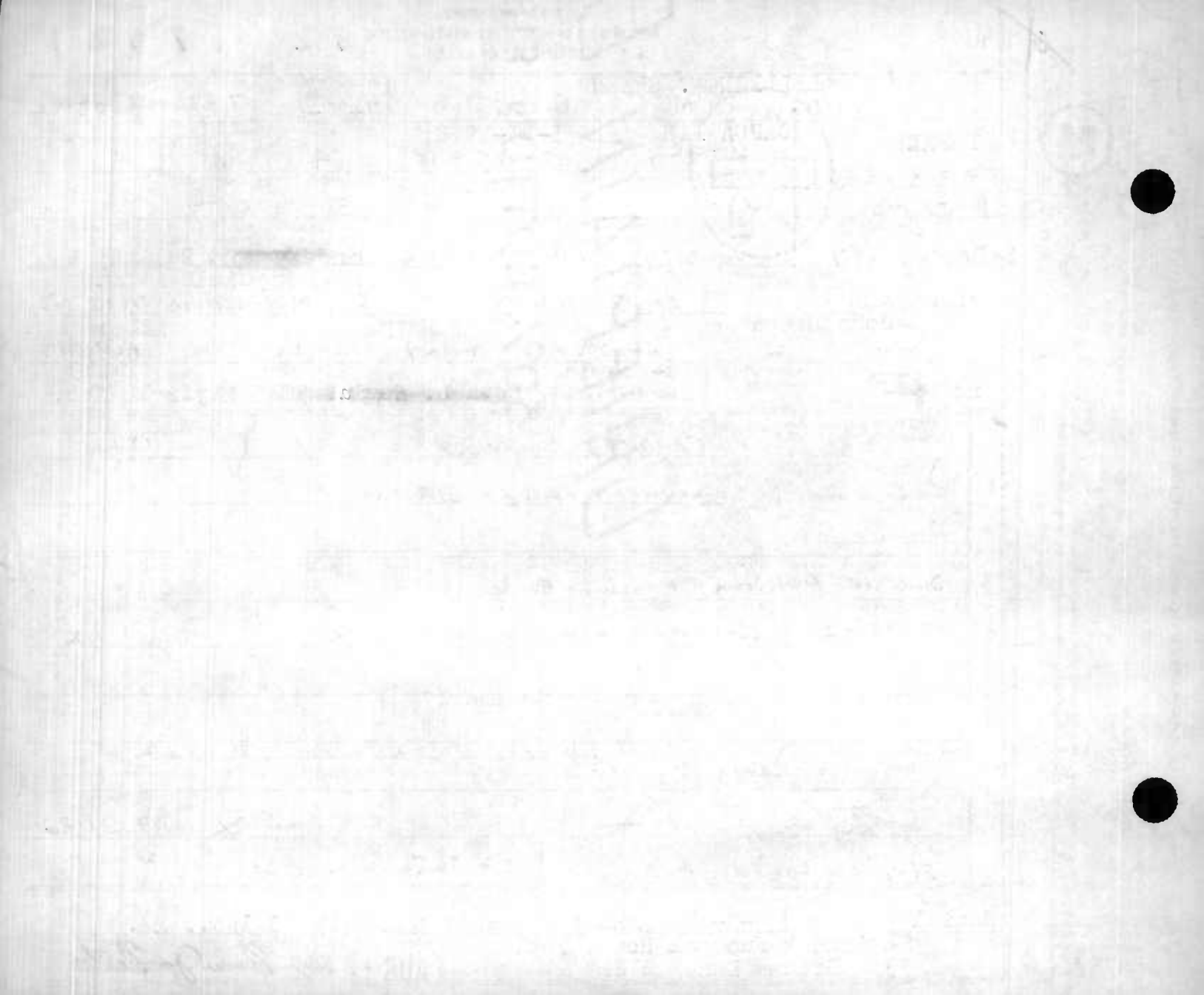
11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 6 3 1 | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian M. Green | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-31-82 07-31-82 | | | 2b. HOUR 03:10AM | | |
| 3. SEX FEMALE | | | 4. RACE CAUCASIAN Cauc. | | | 5. DATE OF BIRTH MONTH DAY YEAR 05-25-1918 05-25-18 | | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 64 64 yrs MONTHS DAYS HOURS MIN. | | |
| 7. BALTIMORE, Md. (COUNTRY) BALTO. MD. | | | 8. CITIZENSHIP (WHAT COUNTRY?) USA | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. CITY | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MD. HOSPITAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bindery Work Dulaney & Verne | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | | 13c. CITY OR TOWN BALTO. CITY | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Green JOHN G. GREEN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Albers MARY E. ALBERS | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no 6-16-6066 21C-16-6066 | | | 17. INFORMANT ADDRESS Leah L. Nevius. 3045 Mayfield Ave. 21213 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes Mellitus; Metabolic Acidosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs | |
| 19a. DATE OF OPERATION 07-30-82 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ATHEROSCLEROSIS | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 28</u> , 19 <u>82</u> , to <u>July 31</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>July 31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stephen Lincoln M.D.</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 07-31-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Lincoln M.D. | | | 22e. ADDRESS 22 South Greene St. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 8-3-82 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery Balto., Md. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane 21213 | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | | 25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u> | | | | | |

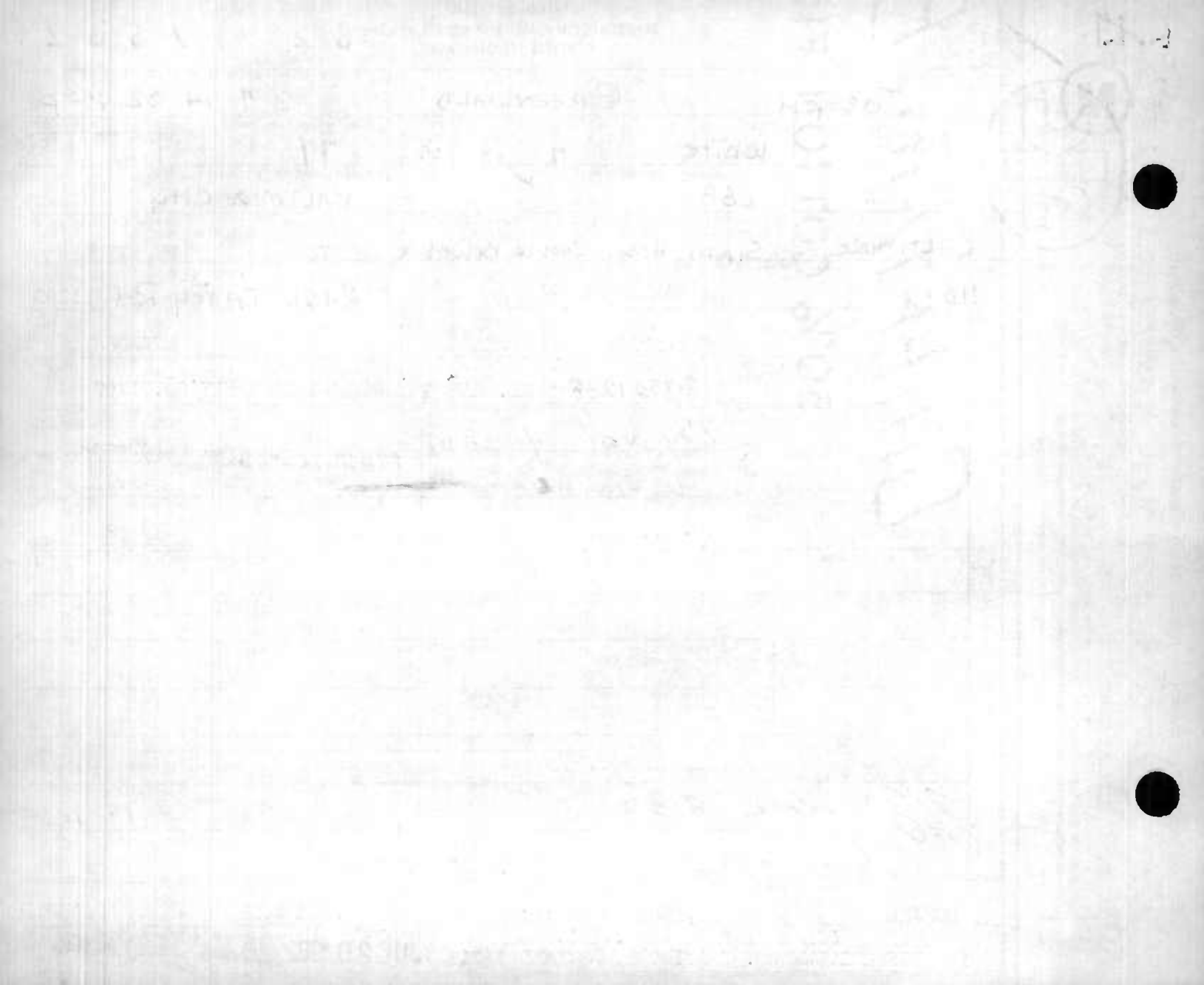


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 6 3 2 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joseph GREENWALD | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 82 | | | 2b. HOUR 453 P.M. | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI Hosp. 2401 W. Belvedere | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETAIL | | 12b. KIND OF BUSINESS OR INDUSTRY FURNITURE | |
| 13a. STATE MD | | 13b. COUNTY BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS APT. 1-D 2926 TANEY Rd 21209 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY GREENWALD | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 21832 1238 | | 17. INFORMANT ADDRESS MRS. RAE GREENWALD 2926 TANEY RD. 21209 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) LONGSTANDING ISCHEMIC DISEASE 46 410 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 46 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE G. Gilliam 9153 | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7.14.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Gilliam | | | | 22e. ADDRESS SINAI HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 16, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | REGISTRAR'S SIGNATURE Frances San Martin | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | | |



2

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 3 3

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) GRACE V. GRIFFIN | | | 2a. DATE OF DEATH MONTH DAY YEAR July 6 1982 | | | 2b. HOUR 5:30 P.M. | | | |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 7 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Deaton | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1710 N. Outland St. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Richardson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216-36-5920 | | 17 INFORMANT Raymond Robinson | | | | ADDRESS 1710 N. Outland | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4360 IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) hypertension, diabetes | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/10 , 19 82 , to 7/6 , 19 82 , that (I) (we) lost saw the deceased alive on 7/6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Dana E King | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dana E King | | | | 22e. ADDRESS Univ of Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus mem. Pt. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD | | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North Ave | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 8 1982 Frances Jan Nathan | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 indicates any injury, or other traumatic event, the medical examiner must be notified and a case filed.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 3 4

2 1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES H. GRIFFIN | | 2a. DATE OF DEATH MONTH 7 DAY 14 YEAR 82 | | 2b. HOUR 10:45 PM | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH 11 DAY 9 YEAR 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montebello State Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1622 Edmondson Avenue | | | |
| 14. FATHER'S NAME FIRST John MIDDLE A. LAST Griffin | | 15. MOTHER'S MAIDEN NAME FIRST Cornelia MIDDLE Johnson LAST Johnson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-07-6387 | | 17. INFORMANT ADDRESS Pearl Grisson 1622 Edmondson Avenue | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 3440 Quadriplegia IMMEDIATE CAUSE (a) Quadriplegia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory Failure, Decubitus ulcers, extensive | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11/17 19 80 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/17/80 to 7/14/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (it) (us) (they) (them) (it) (us) (they) (them) (it) (us) (they) (them) | | | | | |
| 22b. SIGNATURE [Signature] | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE PORTUONDO | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem. Pk. | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. REGISTRAR'S ADDRESS 1101 E. North Ave. | | | |

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|-------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah L. Griffin | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 14 82 | | 2b. HOUR 0700^M | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 03 26 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hosp of Baltimore | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST) MIDDLE LAST Ernest J. Miller | | 15. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST Alma Miller | | 13e. STREET ADDRESS 3420 PARK Heights Ave | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Brenda Rica 3420 Park Heights Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 4280 DUE TO, OR AS A CONSEQUENCE OF (b) chronic Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/27 , 19 82 , to 7/14 , 19 82 , that (I) (we) lost saw the deceased alive on 7/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Neal Kurzrok | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEAL KURZROK | | 22e. ADDRESS Sinai Hosp of Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/19/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cen. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR 15 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nether | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 3 6 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST VERA | | MIDDLE Mary | | LAST GRILLO | | MONTH DAY YEAR JULY 14, 1982 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept 26 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Joseph Lake | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Pajunas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-28-0978 | | 17. INFORMANT ADDRESS Philip L. Grillo 1104 Overbrook Rd 21239 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3949 IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>MITRAL VALVE DISEASE</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 2</u> , 19 <u>82</u> , to <u>JULY 14</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY 14</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard A. Lange MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Lange MD | | | | 22e. ADDRESS 600 Wolfe, Baltimore, Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd 21212 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17637 | |
|--|-------------------------|---|---|---|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ARLENE M. GRIMLEY | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 14 19 82 | | 2b. HOUR M | | | |
| 3. SEX Female | 4. RACE Cauc. | 5. DATE OF BIRTH MONTH 3 DAY 11 YEAR 56 | 6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS. | IF UNDER 1 YR. MONTHS 0 DAYS 0 | IF UNDER 24 HRS. HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD 7 14 19 82 | | 2d. HOUR 8a M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 834 N. Eutaw St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY none | | | |
| 13a. STATE Md. | | 13b. COUNTY Balt. City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 834 N. Eutaw St. | | | |
| 14. FATHER'S NAME FIRST Arthur MIDDLE C. LAST Gunther, Jr. | | | | 15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Horlocker LAST Md. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 216-70-8625 | | 17. INFORMANT Virginia Gunther ADDRESS 3412 25th Pl. Temple Hill Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) Chronic Alcoholism and drug abuse DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Ann M. Dixon | | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | | DATE SIGNED 7-14-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Rseurrection Cemetery | | 23d. LOCATION CITY OR TOWN Clinton COUNTY P.G. STATE Md. | | | | |
| 24. FUNERAL DIRECTOR NAME G.P. Kalas ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

BP

Family

7/17/82

Resurrection Cemetery

Clinton

P.O.

16.

no

216-7-0682

Gunter, Jr.

C.

father

Virginia

Boxlocker

831 W. Putaw St.

X

Baltimore

Palt. City

W.

Unemployed

none

Wash. D.C.

USA

Female Cmc. 3 11 6 26

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Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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| | | | | | |
|---|--|---|---|--|--|
| FOR 1. STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA M. GROTH | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 6, 1982 | | 2b. HOUR P M 10:10 P |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? United States | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corp. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory-worker | 12b. KIND OF BUSINESS OR INDUSTRY Factory | |
| 13a. STATE Maryland | 13b. COUNTY - | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2728 Dillon St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John - Koenigbrauer | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST --- UNKNOWN - - - | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 215-01-8364 | | 17. INFORMANT ADDRESS Albert Groth 2728 Dillon St. | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) WEIGHT LOSS DUE TO, OR AS A CONSEQUENCE OF (c) G.I. BLEEDING, PANCREATICA CANCER, JAUNDIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY, 6</u> , 19 <u>82</u> , to <u>JULY 6</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>July 6</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Mukesh Luhar MD</i> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUKESH LUHAR MD. | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE July 10, 1982 | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE - - Baltimore Co., Md. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i> | |

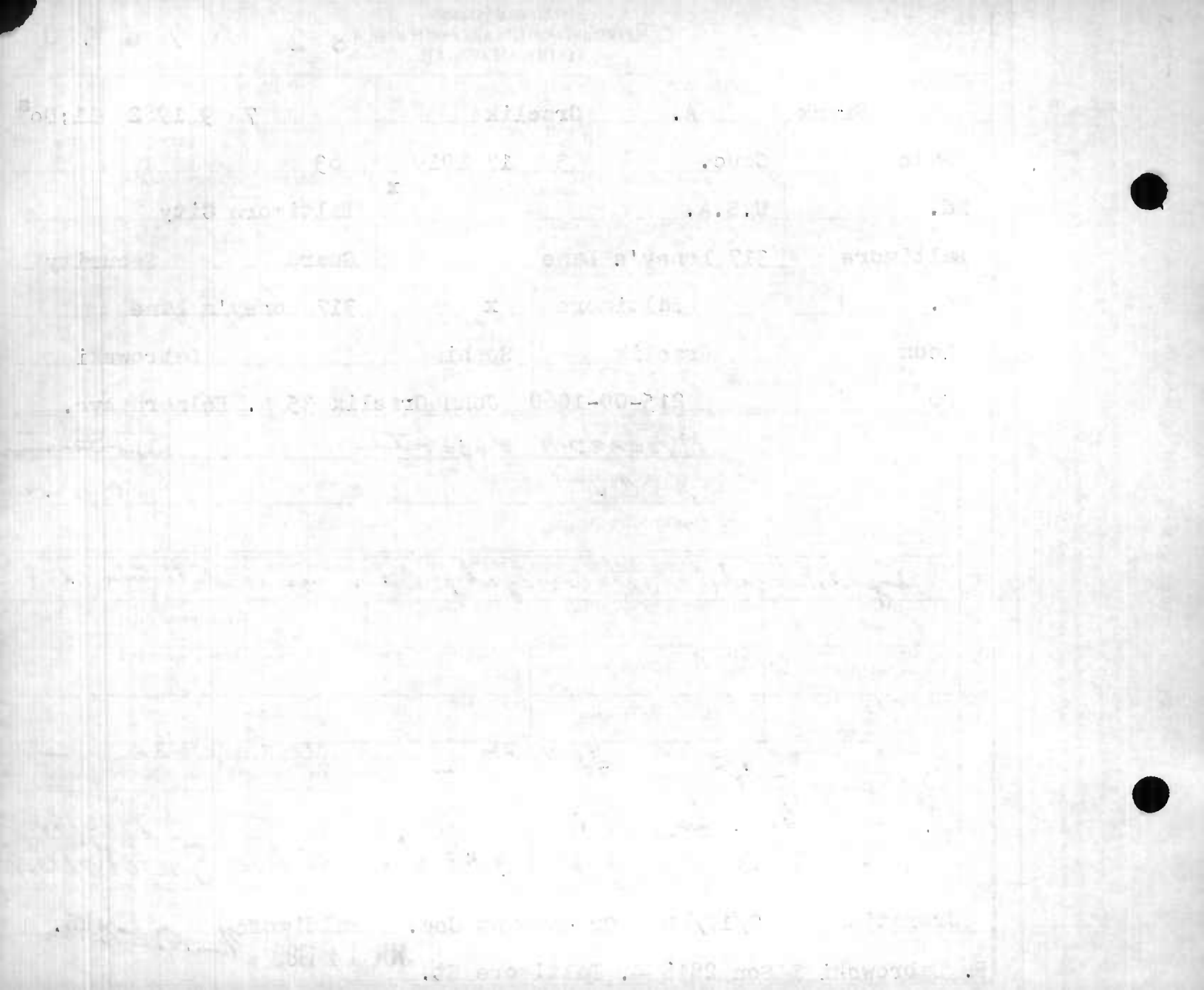
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 6 4 0 | | | |
|--|--|---|----------------------|---|--|--|---|--|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Frank A. Grzelik | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 9 1982 | | | | | 2b. HOUR 11:00a | | | |
| 3 SEX Male | | 4 RACE Cauc. | | 5. DATE OF BIRTH MONTH DAY YEAR 3 17 1919 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 317 Loney's Lane | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guard | | 12b. KIND OF BUSINESS OR INDUSTRY Security | | | | |
| 13a. STATE Md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 317 Loney's Lane | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leon Grzelik | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Dabrowski | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 215-09-1060 | | 17. INFORMANT ADDRESS John Grzelik 35 N. Belnord Ave. | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Spontaneous 10 years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Hypertomegaly - Splenomegaly Etiology undetermined | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION - | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/10/82, 1982, to 7/9, 1982, that (I) (we) lost saw the deceased alive on 7/12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Henry J. Houska MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 7/10/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry J. Houska MD | | | | | 22e. ADDRESS 333 S. EAST AVE BALTO MD 21224 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS E. Dabrowski & Son 2818 E. Baltimore St. | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 14 1982 | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | |
|--|--|---|----------------------|--|---|--|--|--|---|--|--|
| FOR 1. STATE REGISTRAR | | | | | 8 2 1 7 6 4 1 REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LAURETTA VIRGINIA GUE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 13 July 1982 | | | 2b. HOUR 12 ¹⁴ PM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 06/ 21 /06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD. | | | | | |
| 12. CITY OR TOWN OF DEATH BALTIMORE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD | | | | | 16b. COUNTY Baltimore | | 16c. CITY OR TOWN BALTO | | 16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 17. FATHER'S NAME FIRST MIDDLE LAST HARVEY HOUSEHOLDER | | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Hainah | | | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 20. SOCIAL SECURITY NO. 217-22-1311 | | 21. INFORMANT ADDRESS Everett H. Gue 11 Colony Hill Court 21227 | | | | |
| 22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1570 IMMEDIATE CAUSE (a) Carcinoma Head of Pancreas DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Biliary obstruction | | | | | | | | | | | |
| 23a. DATE OF OPERATION | | | | | 23b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 23c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 23d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 25c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 26. I certify that (I) (this hospital) attended the deceased from 25 June 1982, to 13 July 1982, that (I) (we) lost saw the deceased alive on 13 July 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 27a. SIGNATURE Ted Wesley Surtzer M.D. | | | | | 27b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 27c. DATE SIGNED 13 July 1982 | | | |
| 28a. PHYSICIAN'S NAME (TYPE OR PRINT) Ted Wesley Surtzer, M.D. | | | | | 28b. ADDRESS St. Agnes Hospital | | | | | | |
| 29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 29b. DATE 7/16/82 | | 29c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | | 29d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Baltimore Md. | | | |
| 30. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | | 30b. ADDRESS 21229 | | 30c. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 30d. REGISTRAR'S SIGNATURE [Signature] | | |



JUL 1 1884

U.S. DEPT. OF AGRICULTURE

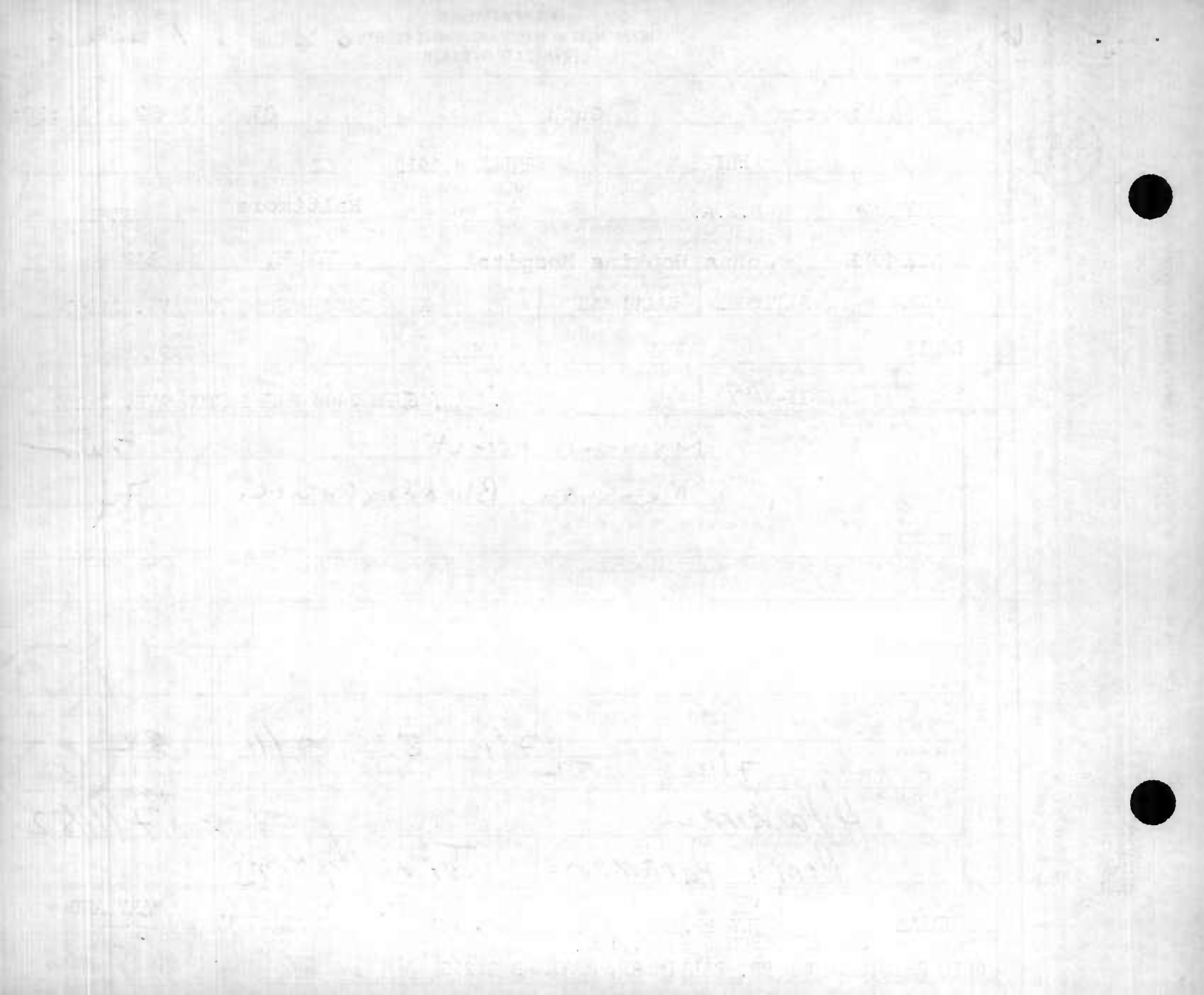
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|---------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 8 2 1 7 6 4 2 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Morton Guth | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 11 82 | | 2b. HOUR 11:30a | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 4, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY | | 12b. KIND OF BUSINESS OR INDUSTRY LAW | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3404 WASHINGTON AVE. 21207 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GUTH | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELE KAPLAN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII-NAVY | | 17. INFORMANT ADDRESS MRS. MARY GUTH 3404 WASHINGTON AVE. 21207 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Respiratory Arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Bladder Cancer | | | | | | | | Fy | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11 19 82 to 7/11 19 82 that (I) (we) lost saw the deceased alive on 7/11 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H Parkman | | | | DEGREE | | | | 22c. DATE SIGNED 7/11/82 | |
| 22d. PHYSICIAN'S NAME, (TYPE OR PRINT) Henry Parkman | | | | 22e. ADDRESS Johns Hopkins | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Harkin | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 4 3 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MILDRED A. GUETHLEIN | | | | 2a. DATE OF DEATH MONTH 7 DAY 27 YEAR 82 2b. HOUR 5:06 A.M. | | | |
| 3. SEX F female | | 4. RACE C White | | 5. DATE OF BIRTH MONTH 7 DAY 16 YEAR 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY Balt. City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Government | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Catonsville | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 5715 Edmondson Avenue | |
| 14. FATHER'S NAME FIRST Frank MIDDLE M. LAST Guethlein | | | | 15. MOTHER'S MAIDEN NAME FIRST Louisa MIDDLE Mary LAST Voih | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-10-3498 | | 17. INFORMANT Mildred A. Brown 1119 S. Wedgewood Road Baltimore, Md. 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Days | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael N. Rubinstein DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael N. Rubinstein | | | | 22e. ADDRESS 3900 N. CHARLES ST., BALTO, MD. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral ADDRESS 1630 Edmondson Ave., Catonsville, Md. 21228 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | |

NOTICE OF PROCEEDINGS



1035 Lombard Ave., Baltimore, Md. 21202
LARRY F. & MARIE E. ALICE HARRIS
7/22/82 Termination of Community Property
Baltimore, Md.

Re: FRANK R. BOWKINS
270-12-438
Baltimore, Maryland
U.S. Court of Appeals
Baltimore, Maryland
270 Lombard Avenue

Wife
270-12-438
Baltimore, Maryland
270 Lombard Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this medical examiner must be notified of the death.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 4 4 | | | |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA M Guidice | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-14-82 | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward J. Flayhart | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kampas | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 218-58-9136 | | 17. INFORMANT ADDRESS Elmer A. Guidice, 1709 Abbotston St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS 5570 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DO TO, OR AS A CONSEQUENCE OF (b) CARDIO-RESPIRATORY FAILURE DO TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GASTRIC OUTLET OBSTRUCTION; ESOPHAGEAL STRICTURE; SEVERE BLE GASTRITIS. | | | | | | | |
| 19a. DATE OF OPERATION 7-13-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAPAROTOMY | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-30 19 82 , to 7-14 19 82 , that (I) (we) lost saw the deceased alive on 7-14 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R.S. Miranda, MD | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIRANDA | | | | 22e. ADDRESS Good Sam. Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 17, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc., Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 14 1982 <i>Thomas J. [Signature]</i> | | | |

27-5

43

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | 8 2 1 7 6 4 5 | |
|---|------------------------------------|---|--|---|---------------|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM T. GUTHRIE | | | | 2a DATE OF DEATH MONTH DAY YEAR JULY 6, 1982 | | 2b HOUR M |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH MONTH DAY YEAR 5/5/13 | | 6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS | | # UNDER 24 HRS MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA | 7b CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | |
| 10 CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CITY HOSP. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY RUE |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY BALTO 13c CITY OR TOWN DUNDALK | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 7514 CARROLL AVE |
| 14 FATHER'S NAME FIRST MIDDLE LAST CLINTON GUTHRIE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE SEYMORE | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK | | 16b SOCIAL SECURITY NO. 233 09 2690 | | 17 INFORMANT ADDRESS MARGARET GUTHRIE ABOVE | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) M.I. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive & Ant. Scl. C V Dis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION CITY OR TOWN COUNTY STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from June 7, 1960, to July 6, 1982, that (I) (we) lost saw the deceased alive on June 15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b SIGNATURE R.G. Windsor | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) R.G. WINDSOR | | 22e ADDRESS 1012 N. Brit Rd. Balt 21224 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL - BURIAL | | 23b DATE 7/9/82 | | 23c NAME OF CEMETERY OR CREMATORY BAYARD CEM | | 23d LOCATION CITY OR TOWN COUNTY STATE BALTO. W. VA. |
| 24 FUNERAL DIRECTOR NAME J.G. CANNELLY | | | | ADDRESS 300 MACE | | 25a DATE REC'D. BY REGISTRAR JUL 13 1982 |
| | | | | 25b REGISTRAR'S SIGNATURE James J. Miller | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR Frank J. Guzik Sr. | | | | | | | | | |
| 2. DATE OF DEATH MONTH DAY YEAR 7 23 82 244R | | | | | | | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST FRANK JOSEPH GUZIK SR. | | | | | | | | | |
| 3. SEX MALE 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 10 5 21 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Se. Balt. Gen. Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder 12b. KIND OF BUSINESS OR INDUSTRY Boiler | | | | | | | | | |
| 13a. STATE md. 13b. COUNTY A.A. 13c. CITY OR TOWN Balto. 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 4109 Bellegrove Rd. (21048) | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Guzik Barbara Sivirat | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII 16b. SOCIAL SECURITY NO. 214-12-9941 17. INFORMANT ADDRESS Vanessa Porter 2997 Bloom Rd. (21048) | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) CARDIOVASCULAR FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CVA DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a.1 certify that (I) (this hospital) attended the deceased from 5/29 , 19 82 , to 7/23 , 19 82 , that (I) (we) last saw the deceased alive on 7/23 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE M. McCarthy DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED 7/23/82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. MCCARTHY 22e. ADDRESS 3001 S. HANOVER ST., BALT. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7/26/82 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy. 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 25b. REGISTRAR'S SIGNATURE Frances Van Natten | | | | | | | | | |

BP



George A. Nichols

George A. Nichols

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George A. Nichols



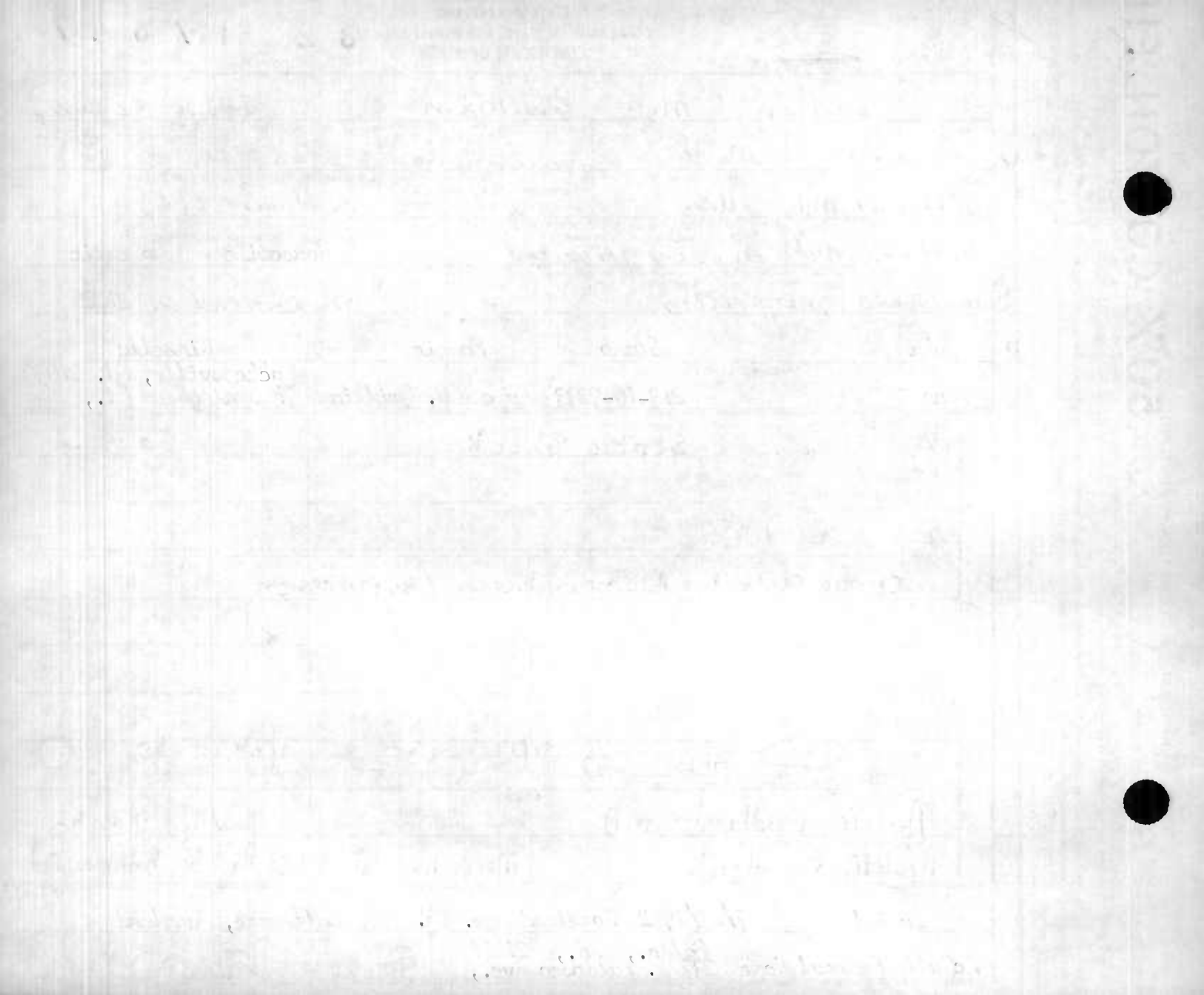
George A. Nichols

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| 1. FOR STATE REGISTRAR <i>Lillian</i> | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. <i>8 2 1 7 6 4 7</i> | | | |
|---|--|---|--|--|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lillian M. Gwilliam</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 20 82</i> | | | | 2b. HOUR <i>10:35 PM</i> | | | |
| 3 SEX <i>Female</i> | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>April 29 1901</i> | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH <i>Baltimore, Md.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Mercy Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i> | | | |
| 13a. STATE <i>MARYLAND</i> | | 13b. COUNTY <i>Baltimore City</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>7916 West End Dr. 21226</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>John Stamp</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maggie Kinsella</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>213-16-9233</i> | | 17 INFORMANT <i>Eugene H. Gwilliam</i> | | | | ADDRESS <i>Cockeysville, Md. 21030 7F Springhead Ct.,</i> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Shock</i> <i>4960</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic obstructive Pulmonary Disease / Hypertension</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/19 82</i> to <i>7/20 82</i> , that (I) (we) last saw the deceased alive on <i>7/20 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Neal M. Friedlander, MD</i> | | | | DEGREE <i>MD</i> | | | | 22c. DATE SIGNED <i>7/20/82</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Neal M. Friedlander</i> | | | | 22e. ADDRESS <i>Mercy Hospital, 301 St. Paul St, Baltimore, Md</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/23/1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Pk.</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i> | | 23e. DATE REC'D. BY REGISTRAR <i>21202</i> | | | |
| 24 FUNERAL DIRECTOR NAME <i>McCully Funeral Home</i> | | | | ADDRESS <i>Balto. Md., 21061 237 E. Patapisco Ave.,</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>Jun 22 1982</i> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>John O. [Signature]</i> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 4 8
REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Abraham Haimovitz | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 17 1982 | | | | 2b. HOUR 4:50p M. | |
| SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 8 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| BIRTHPLACE (COUNTRY) ROMANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER | | 12b. KIND OF BUSINESS OR INDUSTRY PARKING LOTS | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS SHEFFIELD HOUSE 21215 6000 PARK HEIGHTS AVE. APT. 3-A | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN HAIMOVITZ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELA UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. WWI | | 17. INFORMANT ADDRESS MRS. SYLVIA HAIMOVITZ 6000 PARK HEIGHTS AVE. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5850 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure, COPD CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost: more than 30 years more than 30 years | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 28 , 19 82 , to July 17 , 19 82 , that (I) (we) lost saw the deceased alive on July 17 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Chun-Kong Huang | | | | DEGREE | | | | 22c. DATE SIGNED July 17, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chun-Kang Huang | | | | 22e. ADDRESS Sinai Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JULY 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY MOSES MONTEFIORE CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 | | | | | |
| NAME 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | 25b. REGISTRAR James J. Nathan | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified before burial or cremation.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|---|--|--|----------------------------------|---|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 6 4 9 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR | | | | |
| EDITH M. HALE | | | | | 07 26 82 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | White | | MONTH DAY YEAR | | 67 | | 50 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | UNION MEMORIAL HOSPITAL | | | | Homemaker | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. STREET ADDRESS | | | | |
| 13a. STATE COUNTY | | | | | 13b. STREET ADDRESS | | | | |
| Maryland VA. A | | | | | 4405 4th. St. Bk. Balto. 21225 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST | | | | | FIRST MIDDLE LAST | | | | |
| August Gischel | | | | | Maggie Faulkner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | | | 214-01-2173 | | Mr. Samuel E. Hale, Same as Above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| 4476 IMMEDIATE CAUSE (a) Decerebration & coma. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Vascularitis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Brain resection post allergic reaction | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| Cerebral Failure, Diabetic Mellitus. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| None | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24 1982, to 7/26 1982, that (I) (we) saw the deceased alive on 7/26 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | |
| David Leichting | | | | | MD | | 7/26/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | |
| DAVID LEICHTING M.D. | | | | | UNION MEMORIAL HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | July 29, 1982 | | Cedar Hill Cemetery | | Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | |
| NAME ADDRESS | | | | | REGISTRAR'S SIGNATURE | | | | |
| McCully Funeral Home, 237 E. Patapsco Ave. Balto. Md. 21225 | | | | | AUG - 3 1982 Frances Jan. Nathan | | | | |

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775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1001, 1002, 1003, 1004, 1005, 1006, 1007, 1008, 1009, 1010, 1011, 1012, 1013, 1014, 1015, 1016, 1017, 1018, 1019, 1020, 1021, 1022, 1023, 1024, 1025, 1026, 1027, 1028, 1029, 1030, 1031, 1032, 1033, 1034, 1035, 1036, 1037, 1038, 1039, 1040, 1041, 1042, 1043, 1044, 1045, 1046, 1047, 1048, 1049, 1050, 1051, 1052, 1053, 1054, 1055, 1056, 1057, 1058, 1059, 1060, 1061, 1062, 1063, 1064, 1065, 1066, 1067, 1068, 1069, 1070, 1071, 1072, 1073, 1074, 1075, 1076, 1077, 1078, 1079, 1080, 1081, 1082, 1083, 1084, 1085, 1086, 1087, 1088, 1089, 1090, 1091, 1092, 1093, 1094, 1095, 1096, 1097, 1098, 1099, 1100

1101, 1102, 1103, 1104, 1105, 1106, 1107, 1108, 1109, 1110, 1111, 1112, 1113, 1114, 1115, 1116, 1117, 1118, 1119, 1120, 1121, 1122, 1123, 1124, 1125, 1126, 1127, 1128, 1129, 1130, 1131, 1132, 1133, 1134, 1135, 1136, 1137, 1138, 1139, 1140, 1141, 1142, 1143, 1144, 1145, 1146, 1147, 1148, 1149, 1150, 1151, 1152, 1153, 1154, 1155, 1156, 1157, 1158, 1159, 1160, 1161, 1162, 1163, 1164, 1165, 1166, 1167, 1168, 1169, 1170, 1171, 1172, 1173, 1174, 1175, 1176, 1177, 1178, 1179, 1180, 1181, 1182, 1183, 1184, 1185, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1199, 1200

1201, 1202, 1203, 1204, 1205, 1206, 1207, 1208, 1209, 1210, 1211, 1212, 1213, 1214, 1215, 1216, 1217, 1218, 1219, 1220, 1221, 1222, 1223, 1224, 1225, 1226, 1227, 1228, 1229, 1230, 1231, 1232, 1233, 1234, 1235, 1236, 1237, 1238, 1239, 1240, 1241, 1242, 1243, 1244, 1245, 1246, 1247, 1248, 1249, 1250, 1251, 1252, 1253, 1254, 1255, 1256, 1257, 1258, 1259, 1260, 1261, 1262, 1263, 1264, 1265, 1266, 1267, 1268, 1269, 1270, 1271, 1272, 1273, 1274, 1275, 1276, 1277, 1278, 1279, 1280, 1281, 1282, 1283, 1284, 1285, 1286, 1287, 1288, 1289, 1290, 1291, 1292, 1293, 1294, 1295, 1296, 1297, 1298, 1299, 1300

1301, 1302, 1303, 1304, 1305, 1306, 1307, 1308, 1309, 1310, 1311, 1312, 1313, 1314, 1315, 1316, 1317, 1318, 1319, 1320, 1321, 1322, 1323, 1324, 1325, 1326, 1327, 1328, 1329, 1330, 1331, 1332, 1333, 1334, 1335, 1336, 1337, 1338, 1339, 1340, 1341, 1342, 1343, 1344, 1345, 1346, 1347, 1348, 1349, 1350, 1351, 1352, 1353, 1354, 1355, 1356, 1357, 1358, 1359, 1360, 1361, 1362, 1363, 1364, 1365, 1366, 1367, 1368, 1369, 1370, 1371, 1372, 1373, 1374, 1375, 1376, 1377, 1378, 1379, 1380, 1381, 1382, 1383, 1384, 1385, 1386, 1387, 1388, 1389, 1390, 1391, 1392, 1393, 1394, 1395, 1396, 1397, 1398, 1399, 1400

1401, 1402, 1403, 1404, 1405, 1406, 1407, 1408, 1409, 1410, 1411, 1412, 1413, 1414, 1415, 1416, 1417, 1418, 1419, 1420, 1421, 1422, 1423, 1424, 1425, 1426, 1427, 1428, 1429, 1430, 1431, 1432, 1433, 1434, 1435, 1436, 1437, 1438, 1439, 1440, 1441, 1442, 1443, 1444, 1445, 1446, 1447, 1448, 1449, 1450, 1451, 1452, 1453, 1454, 1455, 1456, 1457, 1458, 1459, 1460, 1461, 1462, 1463, 1464, 1465, 1466, 1467, 1468, 1469, 1470, 1471, 1472, 1473, 1474, 1475, 1476, 1477, 1478, 1479, 1480, 1481, 1482, 1483, 1484, 1485, 1486, 1487, 1488, 1489, 1490, 1491, 1492, 1493, 1494, 1495, 1496, 1497, 1498, 1499, 1500

1501, 1502, 1503, 1504, 1505, 1506, 1507, 1508, 1509, 1510, 1511, 1512, 1513, 1514, 1515, 1516, 1517, 1518, 1519, 1520, 1521, 1522, 1523, 1524, 1525, 1526, 1527, 1528, 1529, 1530, 1531, 1532, 1533, 1534, 1535, 1536, 1537, 1538, 1539, 1540, 1541, 1542, 1543, 1544, 1545, 1546, 1547, 1548, 1549, 1550, 1551, 1552, 1553, 1554, 1555, 1556, 1557, 1558, 1559, 1560, 1561, 1562, 1563, 1564, 1565, 1566, 1567, 1568, 1569, 1570, 1571, 1572, 1573, 1574, 1575, 1576, 1577, 1578, 1579, 1580, 1581, 1582, 1583, 1584, 1585, 1586, 1587, 1588, 1589, 1590, 1591, 1592, 1593, 1594, 1595, 1596, 1597, 1598, 1599, 1600

1601, 1602, 1603, 1604, 1605, 1606, 1607, 1608, 1609, 1610, 1611, 1612, 1613, 1614, 1615, 1616, 1617, 1618, 1619, 1620, 1621, 1622, 1623, 1624, 1625, 1626, 1627, 1628, 1629, 1630, 1631, 1632, 1633, 1634, 1635, 1636, 1637, 1638, 1639, 1640, 1641, 1642, 1643, 1644, 1645, 1646, 1647, 1648, 1649, 1650, 1651, 1652, 1653, 1654, 1655, 1656, 1657, 1658, 1659, 1660, 1661, 1662, 1663, 1664, 1665, 1666, 1667, 1668, 1669, 1670, 1671, 1672, 1673, 1674, 1675, 1676, 1677, 1678, 1679, 1680, 1681, 1682, 1683, 1684, 1685, 1686, 1687, 1688, 1689, 1690, 1691, 1692, 1693, 1694, 1695, 1696, 1697, 1698, 1699, 1700

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1801, 1802, 1803, 1804, 1805, 1806, 1807, 1808, 1809, 1810, 1811, 1812, 1813, 1814, 1815, 1816, 1817, 1818, 1819, 1820, 1821, 1822, 1823, 1824, 1825, 1826, 1827, 1828, 1829, 1830, 1831, 1832, 1833, 1834, 1835, 1836, 1837, 1838, 1839, 1840, 1841, 1842, 1843, 1844, 1845, 1846, 1847, 1848, 1849, 1850, 1851, 1852, 1853, 1854, 1855, 1856, 1857, 1858, 1859, 1860, 1861, 1862, 1863, 1864, 1865, 1866, 1867, 1868, 1869, 1870, 1871, 1872, 1873, 1874, 1875, 1876, 1877, 1878, 1879, 1880, 1881, 1882, 1883, 1884, 1885, 1886, 1887, 1888, 1889, 1890, 1891, 1892, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1900

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17650 | |
|--|--------------|---|--|---|---|---|---|---|-----------------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles Hall | | | | | | | | | | 2a. DATE KNOWN OF DEATH 7 18 1982 | |
| 3. SEX M | 4. RACE B | 5. DATE OF BIRTH 3-11-11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 7 19 1982 | | 2b. HOUR 12:28 P.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1525 Presstman Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | 13b. COUNTY | | 13c. CITY OR TOWN Balt | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1525 Presstman St | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ENOCH HALL | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA COOPER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 214-16-8387 | | 17. INFORMANT MARION HALL | | ADDRESS 1224 N. G. Moore St | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-19-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY King Mem PK | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balt | | | |
| 24. FUNERAL DIRECTOR NAME Vernon R. Binkley | | | | ADDRESS 1348 N. Calhoun St | | | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 72. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | Michael Keith Hall | | July 11 1982 | | 5:27 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| M | | B | | MONTH DAY YEAR | | 13 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | USA | | | | BALTO. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTO. | | Died at home 4644 PAUL MALL RD. | | N.A. | | N.A. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| MD. | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4644 PAUL MALL RD. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | NO | | N.A. | | MRS. GERTRUDE HALL 4644 PAUL MALL ROAD | |
| CLYDE | | HALL | | | | | | GERTRUDE WIDEMAN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). 1991 | | DUE TO, OR AS A CONSEQUENCE OF (b). 11 months | | DUE TO, OR AS A CONSEQUENCE OF (c). | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | CARDIORESPIRATORY ARREST | | METASTATIC OSTEOGENIC SARCOMA | | 11 months | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 8/31/81 | | OSTEOGENIC SARCOMA | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug. 1981, to July 11, 1982, that (I) (we) lost saw the deceased alive on July 11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Allen P. Schwartz, M.D. | | | | | | 7/11/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| ALLEN D. SCHWARTZ | | DEPT. PEDIATRICS - U. of Maryland Hosp. - Balto., Md. | | BALTIMORE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 7/17/82 | | MT. AUBURN CEMETERY | | BALTIMORE | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25. JUL 19 1982 | | 26. REGISTRAR'S SIGNATURE | | | |
| LEWIS T. GWYNN | | 4517 PARK HEIGHTS AVENUE | | | | | | | |

LEWIS F. GUYON 4517 PARK HEIGHTS AVENUE

BURIAL 7/17/02 MT. AUBURN CEMETERY BALLINGRAH

ALLEN D. SCHWARTZ

DEPT. F. DIVISION 3

Aug 11 2-11 PM

8/21/04 OSTEOGENIC SARCOMA

NO. 1000 N.A. MRS. GERTRUDE HALL 4044 FILL ROAD

STATE HALL GEORGETOWN

MR. BARTON

BALTO. DIST. COURT HOUSE

RAILROAD USA

14

Michael Keith

1000 N. 10th St. BALTO. MD.

10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17652 | |
|--|-------------------------|---|---|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) DENNIS ROYAL HAMBRUCH | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 7-18-82 | | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 10 DAY 6 YEAR 57 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 24 YRS. | IF UNDER 1 YR. MONTHS 24 DAYS 0 HOURS 0 MIN 0 | 7c. DATE PRONOUNCED DEAD MONTH 7 DAY 20 YEAR 82 | 7d. HOUR 7:34 | | 7e. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Severn River | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glazer - Glass | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | | | | | | 13b. CITY OR TOWN A.A. Co. | | 13c. STREET ADDRESS Annapolis | | |
| 14. FATHER'S NAME FIRST Henry F. MIDDLE Hambruch LAST Sr. | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Margaret A. MIDDLE Colburn LAST Md. | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. 214-72-0100 | | 17. INFORMANT ADDRESS Margaret Hambruch, 19 Madison St., Annp. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-? 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject found floating in water | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) River | | 21f. LOCATION STREET Severn River CITY OR TOWN Annapolis COUNTY Maryland STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margareta Korell | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-21-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita a. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial | | | 23b. DATE 7-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery | | | 23d. LOCATION STREET Annapolis COUNTY Maryland STATE | | | |
| 24. FUNERAL DIRECTOR NAME Beall Funeral Home, 1212 West St., Annp., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Martin | | | |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 5 3

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Audrey I Hamilton | | | 2a. DATE OF DEATH MONTH DAY YEAR July 7, 1982 | | 2b. HOUR 4:30 A.M. |
| 3. SEX FEMALE | 4. RACE CAUCASIAN | 5. DATE OF BIRTH MONTH DAY YEAR 7-28-17 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MARYLAND | | 13b. COUNTY --- | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CLAUDE ----- HOGAN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY V NEARY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-18-7088 | | 17. INFORMANT ADDRESS Donald L. Hamilton, Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 28 , 19 82 , to July 7 , 19 82 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 7 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE James T. Heiser, M.D. | | DEGREE | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James T. Heiser M.D. | | 22e. ADDRESS 3001 South HANNOVER STREET | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | 24. FUNERAL DIRECTOR NAME ADDRESS McUllly Funeral Home, 130 E. Fort Ave. Balto. Md. | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE REC'D. BY REGISTRAR | |
| JUL 7 1982 | | Charles J. Smith | | JUL 7 1982 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2404 BP

DMHM - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 6 | 5 | 4 | | | |
|--|--|--|------------------------------|--|--|--|--|--|--------------------------------------|--|---|--|-----------------------------------|---|----------------------|---|----------------------------|---------------------|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| GEORGE HAMILTON SR. | | | | | | | | | | 7 30 82 10 P.M. | | | | | | | | | |
| 3 SEX | | | 4 RACE | | | 5. DATE OF BIRTH | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| M | | | B. | | | 10 9 18 | | | 63 YRS. | | | MONTHS DAYS | | HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | |
| ALABAMA | | | USA. | | | | | | BALTIMORE CITY MD. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| BALTIMORE | | | | | N-CHARLES GEN HOSP. | | | | | | | | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | |
| MD. | | | | | | | | | | BALTO. | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 6820 E-RIDGE RD. | |
| 14 FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| THOMAS HAMILTON | | | | | CASSIE SUGAR | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17 INFORMANT ADDRESS | | | | | | | | | |
| | | | | | 408143677 | | | | | George Hamilton Jr. | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| IMMEDIATE CAUSE (a) 1539 | | | | | | | | | | CARDIO-RESPIRATORY FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 1539 | | | | | | | | | | RENAL FAILURE | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) 1539 | | | | | | | | | | RECURRENT COLON CARCINOMA. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | MYOCARDIAL CONDUCTION SYSTEM DISEASE POSSIBLY ALSO MI. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| UNKNOWN | | | | | RECTAL CARCINOMA. | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| | | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | |
| | | | | | P.M. 19 | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY | | | | | 21f. LOCATION | | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | CITY OR TOWN STREET COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from | | | | | | | | | | 22b. SIGNATURE | | | | | | | | | |
| 7/20/82 to 7/30/82 | | | | | | | | | | 7/30/82 | | | | | | | | | |
| saw the deceased alive on 7/30/82, and that in (my) (did) (did not) view the body after death. | | | | | | | | | | DEGREE | | | | | | | | | |
| | | | | | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| SYED MOHSIN ALI HASSAN | | | | | | | | | | N-CHARLES GEN. HOSP. BALTO. MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION | | | | |
| Burial | | | | | 8/5/82 | | | | | Arbutus | | | | | Baltimore County Md. | | | | |
| 24 FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| G. L. Phelps | | | | | | | | | | AUG - 2 1982 | | | | | | | N. M. M. M. M. | | |

GEORGE HAMILTON JR 2 30 1919

M D 10 1 1919
ALABAMA USA
BIRMINGHAM CITY

BAT PIERCE-CHARLES (FERN HOP)
MD 10 1 1919

THOMAS
WOMING, IT was in 1919

CARDIO-RESPIRATORY FAILURE
RENAL FAILURE

RECURRENT CORONARY ARTERY
DISEASE

✓
RECTAL EXAMINATION

1919 - 1919 - 1919

✓ 1919 - 1919 - 1919

1919 - 1919 - 1919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 6 5 5 | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| KATHRYN EDNA HAMILTON | | | | July 2, 1982 | | | | 6 A.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS, LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | |
| Female | | White | | Dec. 9 DAY 1896 | | 85 | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Penna. | | USA | | | | Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 123 W. 29th St. | | | | Seamstress | | Dress Mfg. | | | |
| 13a. STATE | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 123 W. 29th St. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Charles Doble | | | | Agatha Machonis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT: Self- 1970 ADDRESS | | | | | |
| NO | | | | 215-07-2048 A | | Kathryn E. Hamilton | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vascular Disease</u> | | | | | | | | | | 10 years | |
| 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> | | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 25, 1972</u> to <u>July 2, 1982</u> , that (I) (we) lost saw the deceased alive on <u>—</u> 19 <u>—</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| <u>W. Gratton Hersperger M.D.</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 7/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| W. G. Hersperger, M.D. | | | | 214 Medical Arts Building | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | | | 7/6/82 | | Woodlawn | | Woodlawn, Balto. Co., Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| STEWART & MOWEN CO. 108 W. North Av., 21201 | | | | | | JUL 6 1982 | | <u>W. N. Nutter</u> | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 5 6

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN J. HAMILTON | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 12 82 | | | 2b. HOUR 5 20 AM | |
| 3 SEX FEMALE | | 4 RACE CAUC. | | 5. DATE OF BIRTH MONTH DAY YEAR 6/2/06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | |
| 13a. STATE MD. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? ? ? | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. — | | 17. INFORMANT DAUGHTER | | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Severe, Chronic Lung Disease and Renal Disease DUE TO, OR AS A CONSEQUENCE OF (c) Severe, Chronic Congestive Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 HOURS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | |

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/11, 19 82, to 7/12, 19 82, that (I) (we) lost saw the deceased alive on 7/12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Andrew J. Lee MD | | | | DEGREE | | 22c. DATE SIGNED 5/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew J. Lee MD | | | | 22e. ADDRESS 2600 Liberty Hts Ave, Baltimore, Md. | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW | | 23d. LOCATION CITY OR TOWN COUNTY STATE CARROLL CO., MD. | |
| 24. FUNERAL DIRECTOR Paul Chenoweth's | | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

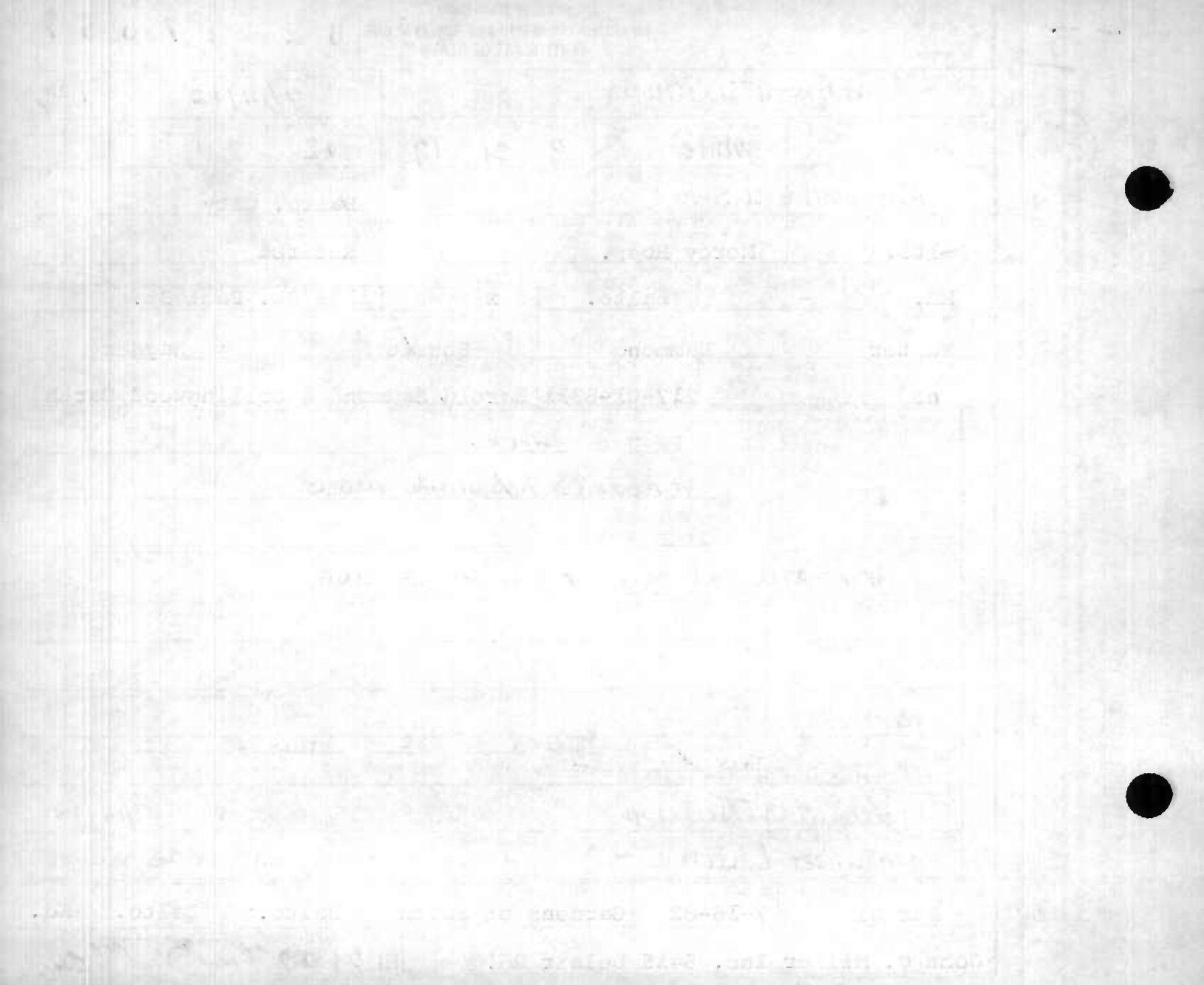
5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are derived from the principles of relativity and the theory of the structure of the atom.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 6 5 7 | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) KENNETH R. HAMMOND | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/14/82 | | | 2b. HOUR 6:20 P.M. | |
| 1. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR 8 21 19 62 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1129 St. Paul St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Walter Hammond | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Wagner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-01-6331 | | 17. INFORMANT ADDRESS Harold Hammond 4 Collingwood Garth | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTIC SHOCK 1629 DUE TO, OR AS A CONSEQUENCE OF (b) PERFORATED ABDOMINAL VISCUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) METASTATIC OAT CELL CARCINOMA OF LUNG | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 1 , 19 82 , to JULY 14 , 19 82 , that (I) (we) lost saw the deceased alive on JULY 14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Sergeant J. Keeler | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET L. KEELER, M.D. | | | | 22e. ADDRESS MERCY HOSPITAL, BALTIMORE, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-18-82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Balto. Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc. 6415 Belair Rd. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 6 5 8 | | | | | |
|---|--|---------|--|---|--|------------------------------------|--|--|--|---|--|---|--|---------------------|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LEWIS H. HAMMOND | | | | July 13, 1982 | | | | | | | | | | 12:07P _M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Black | | MONTH 12 DAY 26 YEAR 1927 | | | | 54 YRS | | | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Anne Arundel Co. | | | | U. S. A. | | | | | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | | Maryland General Hospital | | | | Laborer | | | | Construction | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| Maryland | | | | | | | | Baltimore | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 13e. STREET ADDRESS | | | | | | | |
| FIRST MIDDLE LAST Aulbin Hammond | | | | FIRST MIDDLE LAST Irene Jackson | | | | 536 McMechen Street | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| Yes <input checked="" type="checkbox"/> Korean | | | | 217 24 0143 | | | | Lorraine Bowie | | | | 1713 Nursery Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) <u>Metabolic acidosis</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> | | | | | | | | | | | | years | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 9</u> , 19 <u>82</u> , to <u>July 13</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 13</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED | | | | | |
| Cheryl Powell | | | | | | | | M.D. | | 7/13/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | 22e. ADDRESS | | | | | | | |
| Cheryl Powell, M.D. | | | | | | | | c/o Maryland General Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (CITY OR TOWN) COUNTY | | | | | |
| Burial | | | | 7/16/82 | | MD VETERANS | | | | Crownsville MD | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| J.P. Harris | | | | 6387 91/mor st | | | | JUL 14 1982 James Jean Nathan | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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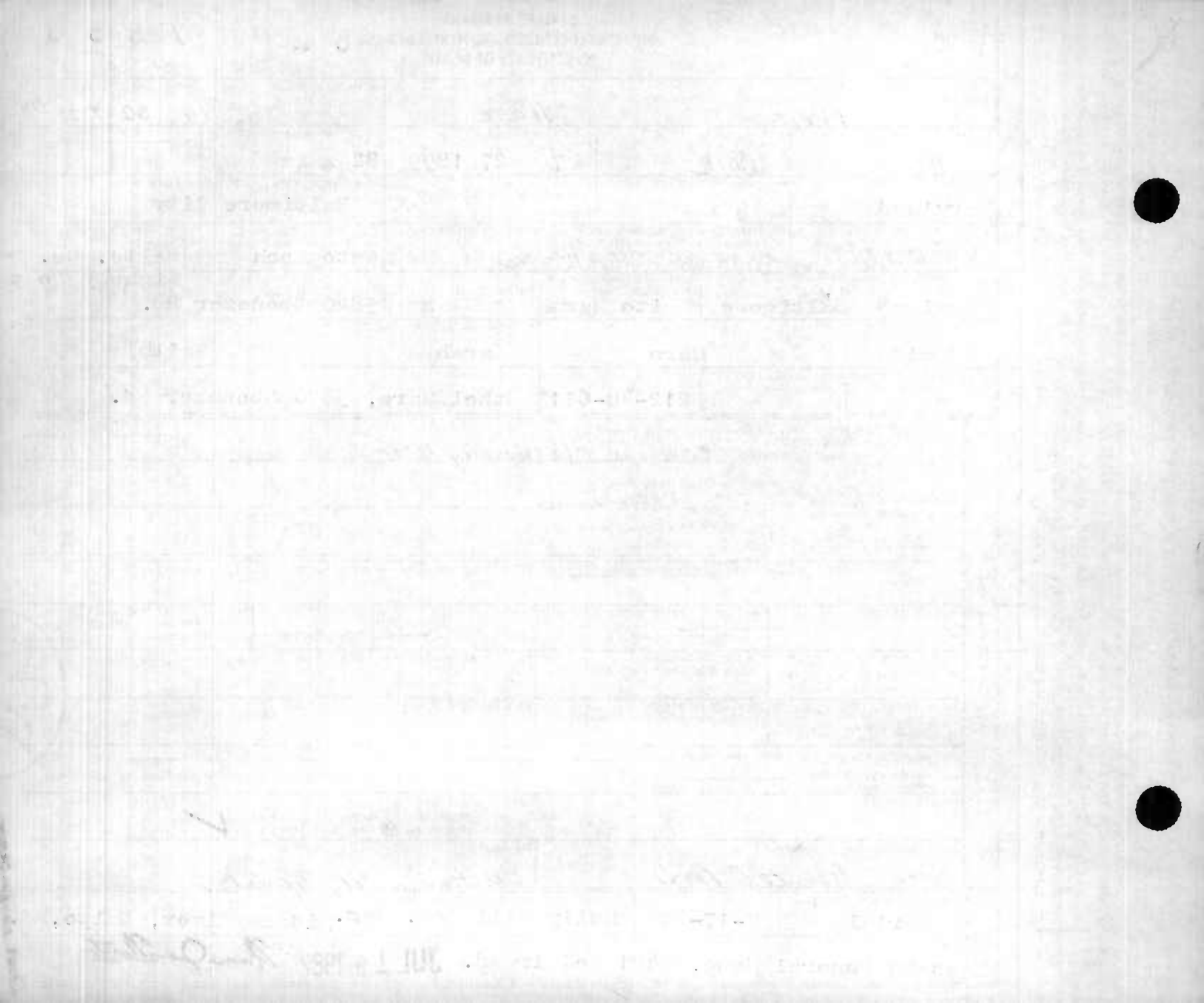
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 5 9 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2. DATE OF DEATH | | | |
| ROBERT ^{FIRST} ^{MIDDLE} Arthur ^{LAST} HANNA | | | | 7/31/82 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | 6-10-1922 | | 60 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MO | | USA | | | | BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | WYMAN PARK HEALTH SYS. INC. | | RETIRED ARMY | | RETIRED | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| MO | | Joppa | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2606 OLD JOPPA RD | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17. INFORMANT | |
| WILLIAM ^{FIRST} ^{MIDDLE} S. ^{LAST} HANNA | | Helen ^{FIRST} ^{MIDDLE} Rebecca ^{LAST} BANNISTER | | YES <input type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) | | MEDICAL RECORDS INPHS | |
| 16a. SOCIAL SECURITY NO | | 17. ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 215387702 | | | | PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST | | 20 MIN. | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF STOMACH | | 3 WKS | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) UK | | UK | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: VENTRICULAR BRADYCARDIA; LIVER CA METASTASIS | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| NA | | NA | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. LOCATION | |
| NA | | NA | | NA | | NA | |
| 21e. INJURY OCCURRED | | 21f. PLACE OF INJURY | | 21g. LOCATION | | 21h. LOCATION | |
| NA | | NA | | NA | | NA | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | 22d. SIGNATURE | |
| F. Delgado MD | | | | 7/31/82 | | 2211 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | 22g. ADDRESS | | 22h. ADDRESS | |
| FERNANDO A. DELGADO | | W.P.H.S.I. 3100 WYMAN PARK DR | | BALTIMORE | | BALTIMORE | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Aug. 4, 1982 | | Darlington Cemetery | | Darlington, Harford Md. | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 24c. ADDRESS | | 24d. ADDRESS | |
| Howard K. McComas III | | Abingdon, Md. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|---|---|--|--|-------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | | | 8 2 1 7 6 6 0 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Albert Hare</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 14 82</i> | | | | | 2b. HOUR <i>9:25 PM</i> | | | | |
| 3 SEX <i>M</i> | | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>7 27 1899</i> | | | 6 AGE (IN YEARS LAST BIRTHDAY) <i>82 63x</i> YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD | | | | | | |
| 10 CITY OR TOWN OF DEATH <i>Baltimore City</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i> | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Auto Mech</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Co.</i> | | | |
| 13a. STATE <i>Maryland</i> | | | | | 13b. CITY OR TOWN <i>Baltimore</i> | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>5820 Ebenezer Rd.</i> | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST <i>David Hare</i> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Smith</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | | | | 16b. SOCIAL SECURITY NO. <i>212-40-6113</i> | | 17 INFORMANT ADDRESS <i>Ethel Hare, 5820 Ebenezer Rd.</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>4860 IMMEDIATE CAUSE (a) cardiac / Alimentary Arrest</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John J. Smith MD</i> | | | | | 22e. ADDRESS <i>Baltimore City Hospital</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | | 23b. DATE <i>7-17-82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holly Hill Mem. Gar.</i> | | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Middle River, Balto, Md.</i> | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home, 7401</i> | | | | | 25. DATE REC'D. BY REGISTRAR <i>JUL 19 1982</i> | | | | | 26. REGISTRAR'S SIGNATURE <i>James J. Smith</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|---|--|--|---|---|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E. Hargest | | | 2a. DATE OF DEATH MONTH DAY YEAR July 27, 1982 | | 2b. HOUR M M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 6, 1899 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | IF UNDER 1 YEAR MONTHS DAYS YRS | | IF UNDER 24 HRS HOURS MIN. MD | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH City | | 10. CITY OR TOWN OF DEATH Baltimore | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4702 B. York Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Kaufman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Muth | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO OR UNKNOWN no | | |
| 16b. SOCIAL SECURITY NO. 212-01-9708 | | 17. INFORMANT ADDRESS Mr. Donald Hargest 5 L. Quiet Stream Ct. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Infection in left stump DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) several years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. ASCVD several years | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCVD | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. SIGNATURE E. Ellsworth Cook MD | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) E. Ellsworth Cook MD | | 22c. DATE SIGNED 7.27.82 | | 22d. ADDRESS 2431 Maryland Avenue Baltimore, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto. Md. | | 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

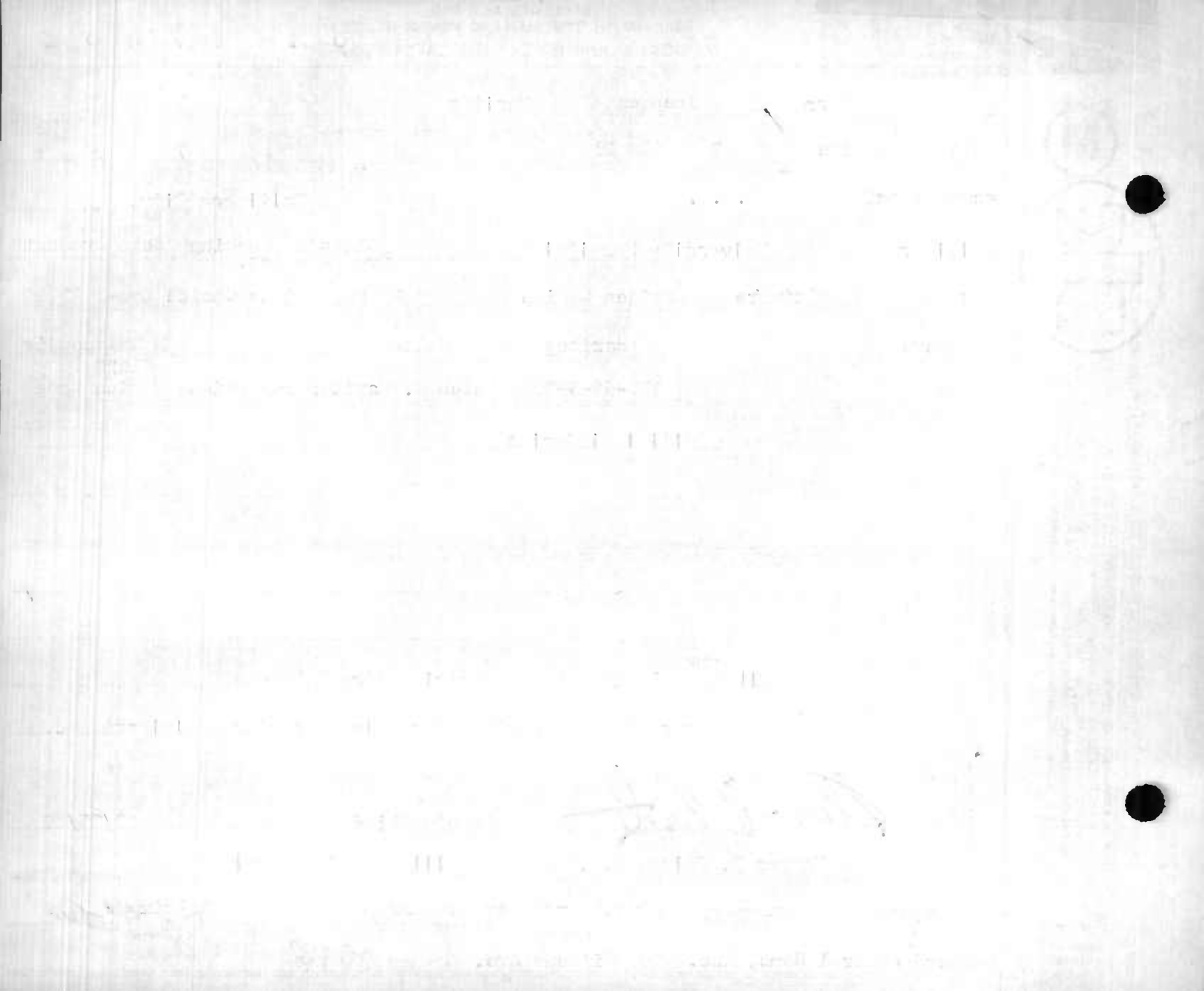
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--------------------------|--|-------------------|--|-------------------------|--|------------------|--|---|--|--|--|--------------------------------------|--|--|--|--|--|----------------------------|--|---|--|-------|--|--|--|--|--|--|--|--|--|---------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. DATE OF ESTI- MATED | | | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | | | | | | | | | | | | | | | | | | | | |
| George Stephen Haritos | | | | 7 25 1982 | | | | 7 25 1982 | | | | a M | | | | 7 25 1982 | | | | a M | | | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12. USUAL OCCUPATION | | 13. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Male | | White | | 3 2 61 | | 21 YRS. | | MONTHS | | DAYS | | U.S.A. | | <input type="checkbox"/> NEVER MARRIED | | Baltimore City, MD. | | Baltimore | | University Hospital | | Cleaning, Cooking Products | | Ecko Products | | | | | | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | | 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | |
| Maryland | | | | Baltimore | | | | Maiden Choice | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 905 Maiden Choice Lane 21229 | | | | Steve Haritos | | | | Helen Galanoudis | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | 21229 | | | | 21229 | | | | 21229 | | | | | | | | | | | | | |
| NO | | | | 217-66-5929 | | | | Helen G. Haritos | | | | 905 Maiden Choice Lane | | | | 905 Maiden Choice Lane | | | | 905 Maiden Choice Lane | | | | 905 Maiden Choice Lane | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | | | 21c. HOW INJURY OCCURRED | | | | | | | | | | | | | |
| 11:42 P.M. | | | | | | | | | | | | 7 24 1982 | | | | | | | | | | | | pedestrian struck by van | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | | | 21e. PLACE OF INJURY | | | | | | | | | | | | 21f. LOCATION | | | | | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | | | | | | | | | street | | | | | | | | | | | | Southwestern Blvd, Arbutus, Baltimore, Md. | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held on | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| death resulted from: <input checked="" type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | | | DATE SIGNED | | | | | | | | | | | | | |
| Thomas D. Smith, M.D. | | | | | | | | | | | | M.D. Deputy Chief | | | | | | | | | | | | 7/25/82 | | | | | | | | | | | | | |
| EXAMINER'S NAME | | | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | |
| (TYPE OR PRINT) | | | | | | | | | | | | 111 Penn St. Balto., MD. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | | | | | | | | | | 23b. DATE | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | 23d. LOCATION | |
| Burial | | | | | | | | | | | | 07-28-82 | | | | | | | | | | | | Greek Orthodox Cemetery | | | | | | | | | | | | Woodlawn | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | 25b. REGISTRAR | | | | | | | | | | | | | |
| NAME | | | | | | | | | | | | 21229 | | | | | | | | | | | | 26 1982 | | James | | | | | | | | | | | |
| Hubbard Funeral Home, Inc. | | | | | | | | | | | | 4107 Wilkens Ave. | | | | | | | | | | | | | | | | | | | | | | | | | |

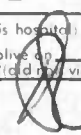
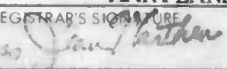
BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 6 6 3 REG. NO. | | | |
|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HERBERT J HARMATZ | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 16 1982 | | 2b. HOUR 4 P M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 17, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS MONTHS DAYS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) 5702 STUART AVE. 21215 | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 5702 STUART AVE. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MORRIS HARMATZ | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA SELENKOW | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WWII-ARMY | | | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT WILLIAM HARMATZ | | ADDRESS 6209 WESTERN RUN DR. BALTO., MD 21209 | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 MI IMMEDIATE CAUSE (a) MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: ASCVD AND DM DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-16 , 19 82 , to 7/16 , 19 82 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 7-16 , 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE  | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-16-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR ARTHUR M. LEVINSON MD | | 22e. ADDRESS 3610 FOROS LANE 21215 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 18, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | 25. DATE REC'D. BY REGISTRAR JUL 20 1982 25b. REGISTRAR'S SIGNATURE  | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS - 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

REG. NO.

7 6 6 4

| | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--------------------------------------|--|---|--|---|--|
| 1- FOR REGISTRAR | | 2- FOR MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 3- FOR REG. NO. 17664 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTD. MONTH DAY YEAR | | 2b. HOUR | |
| Frank | | S. | | | | Harper | | X | | 7 25 82 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| M | | Blk | | 7 18 52 | | 30 | | MONTHS | | DAYS | | 7 25 82 | |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | |
| BALTO. Md. | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City | | Baltimore | | 900 Blk Harlem Avenue | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Self Employed | | Grocer | | Md. | | | | BALTO | | YES X NO | | 5410 FAIRLAWN AVE. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | |
| Stanley | | Dorothy | | No | | | | Dorothy HARPER | | 5410 FAIRLAWN | | PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds WEAPON: Handgun Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 22a. I certify that I took charge of the remains described above, held on | |
| | | | | YES X NO | | UNDERLYING OR CONTRIBUTING CAUSE OF DEATH | | 11: XX P.M. 7/25 1982 | | subject shot | | Autopsy X Inspection Inquiry and in my opinion | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | 21g. CITY OR TOWN | | 21h. COUNTY | | 21i. STATE | | death resulted from: Natural causes Accident Suicide Homicide Undetermined manner | |
| WHILE AT WORK X NOT WHILE AT WORK | | grocery Store | | 915 Harlem Avenue, Baltimore, MD | | | | | | | | X | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | | 24. FUNERAL DIRECTOR NAME | |
| Burial | | 7-29-82 | | King Mem Pk | | Randallstown | | Md. | | | | Jas. A. MORTON & SONS | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | 25c. DATE REC'D. BY REGISTRAR | | 25d. REGISTRAR'S SIGNATURE | | 25e. DATE REC'D. BY REGISTRAR | | 25f. REGISTRAR'S SIGNATURE | | 25g. DATE REC'D. BY REGISTRAR | |
| JUL 27 1982 | | James Van Natten | | JUL 27 1982 | | James Van Natten | | JUL 27 1982 | | James Van Natten | | JUL 27 1982 | |

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U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 6 5

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ALVIN W HARRIS | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 02 1982 | | 2b. HOUR 7a.m. |
| 3. SEX MALE | 4. RACE NEGRO | 5. DATE OF BIRTH MONTH DAY YEAR 03 08 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Car | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAT HOSP INC | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE md | | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216038417 | | 17. INFORMANT ADDRESS Marie Harris 4403 Bell Ave. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic Failure and Renal Failure
5751
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Gross hepatic disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

± 1 week

> 1 year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

aortic aneurysm + cholecystitis

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION 6/4/82 6/4/82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cholecystitis aortic aneurysm | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 06/1/82, 1982, to 07/2, 1982, that (we) last saw the deceased alive on 07/2, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. | | | |
| 22b. SIGNATURE R SEGAL | DEGREE MBChB | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 07/02/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R SEGAL | | 22e. ADDRESS C/O SINAT HOSP BALTO | |

| | | | |
|---|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (IF Y) Burial | 23b. DATE 7/6/82 | 23c. NAME OF CEMETERY OR CREMATORY Ind. Mt. Cem. | 23d. LOCATION CITY OR TOWN COUNTY STATE Lanesh Md |
| 24. FUNERAL DIRECTOR NAME Leroy A. Dyett | | ADDRESS 4600 Liberty Hgts | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 |
| | | 25b. REGISTRAR'S SIGNATURE Thomas J. Norton | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Clarence

B.

Harris

2a. DATE KNOWN
OF DEATH
ESTIMATED

MONTH

DAY

YEAR

2b. HOUR

M

7

24

1982

2c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d. HOUR

M

7

24

1982

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Johns Hopkins Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

13c. CITY OR TOWN

BALTIMORE

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS

2414 Calvert Street

14. FATHER'S NAME

UNKNOWN

15. MOTHER'S MAIDEN NAME

THEODOSIA

MIDDLE

HARRIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

224-16-1297

17. INFORMANT

ADDRESS

Evelyn Harris 2414 Calvert Street

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound of head

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR 7 MONTH 24 DAY 19 YEAR 82
P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Self inflicted

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

home

21f. LOCATION
STREET

2414 N. Calvert St. Balto.

CITY OR TOWN

COUNTY

STATE

Md.

22a. I certify that I took charge of the remains described above, held an
death resulted from: ☐ Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

TITLE (SPECIFY)

Deputy Chief MEDICAL EXAMINER

DATE
SIGNED 7/25/82ACTUAL
SIGNATUREEXAMINER'S NAME
(TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

7-30-82

23c. NAME OF CEMETERY OR CREMATORY

EASTVIEW

23d. LOCATION
CITY OR TOWN

BALTIMORE

COUNTY

STATE

MD.

24. FUNERAL DIRECTOR

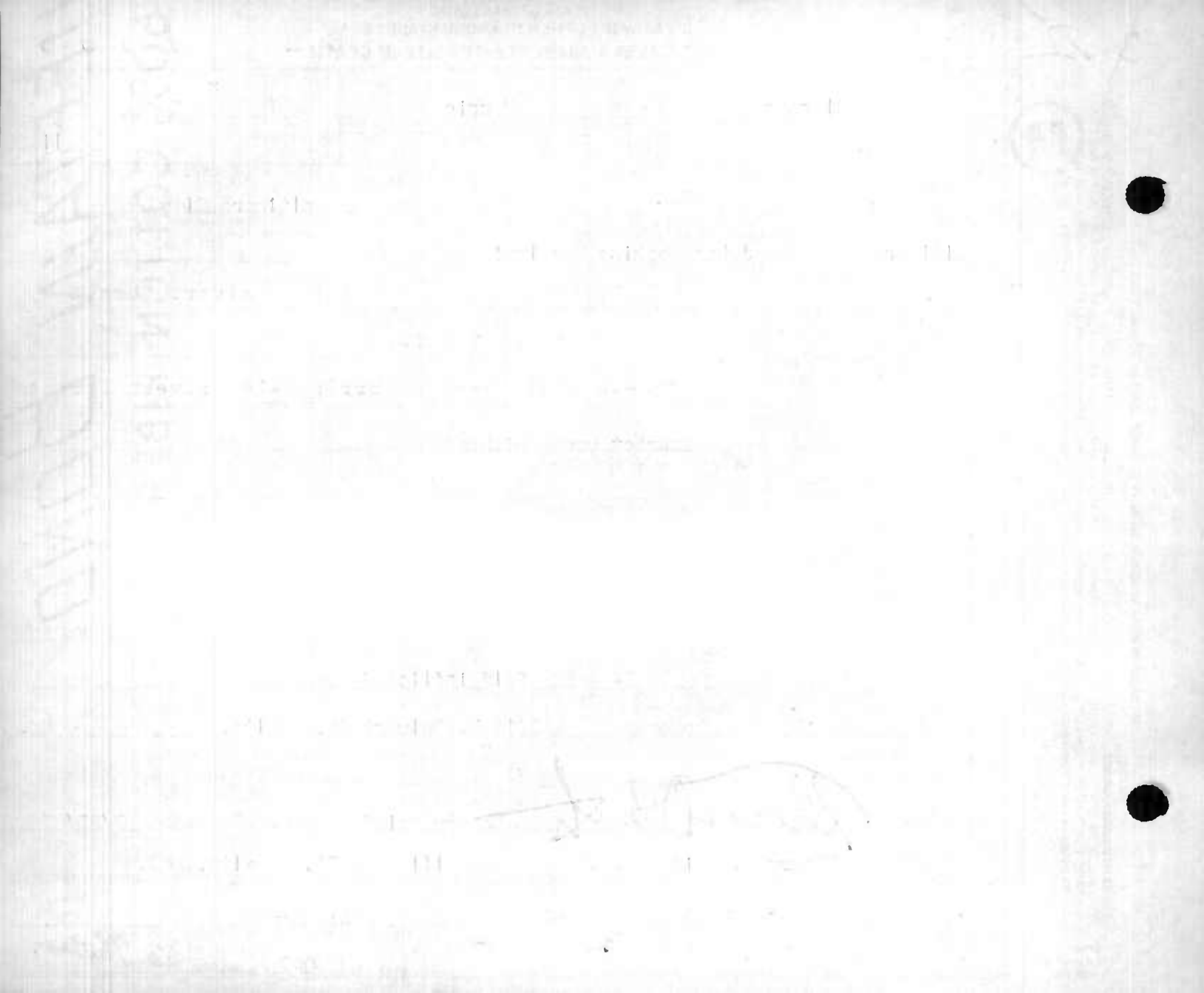
MARCH F/H 1101 E. NORTH AVENUE

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUL 26 1982

James J. Nathan



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 17667 | | | |
|--|--|----------------------|--|--|--|---|--|--|--|---|--|--|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DOUGLAS HARRIS | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> 7-4-82 | | MONTH DAY YEAR | | 7b. HOUR 10:45 | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 17 54 | | 6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 7-4-82 | | MONTH DAY YEAR | | 7b. HOUR 10:45 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1700blk. Normal Avenue (in an auto) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN Baltimore | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Harris | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | | | 13e. STREET ADDRESS 2434 Druid Hill Avenue | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 218-60-3119 | | | | 17. INFORMANT ADDRESS Corrine Harris 2434 Druid Hill Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-4-82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | | | 25b. REGISTRAR'S SIGNATURE James J. North | | | | | | | |



RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72-hour certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

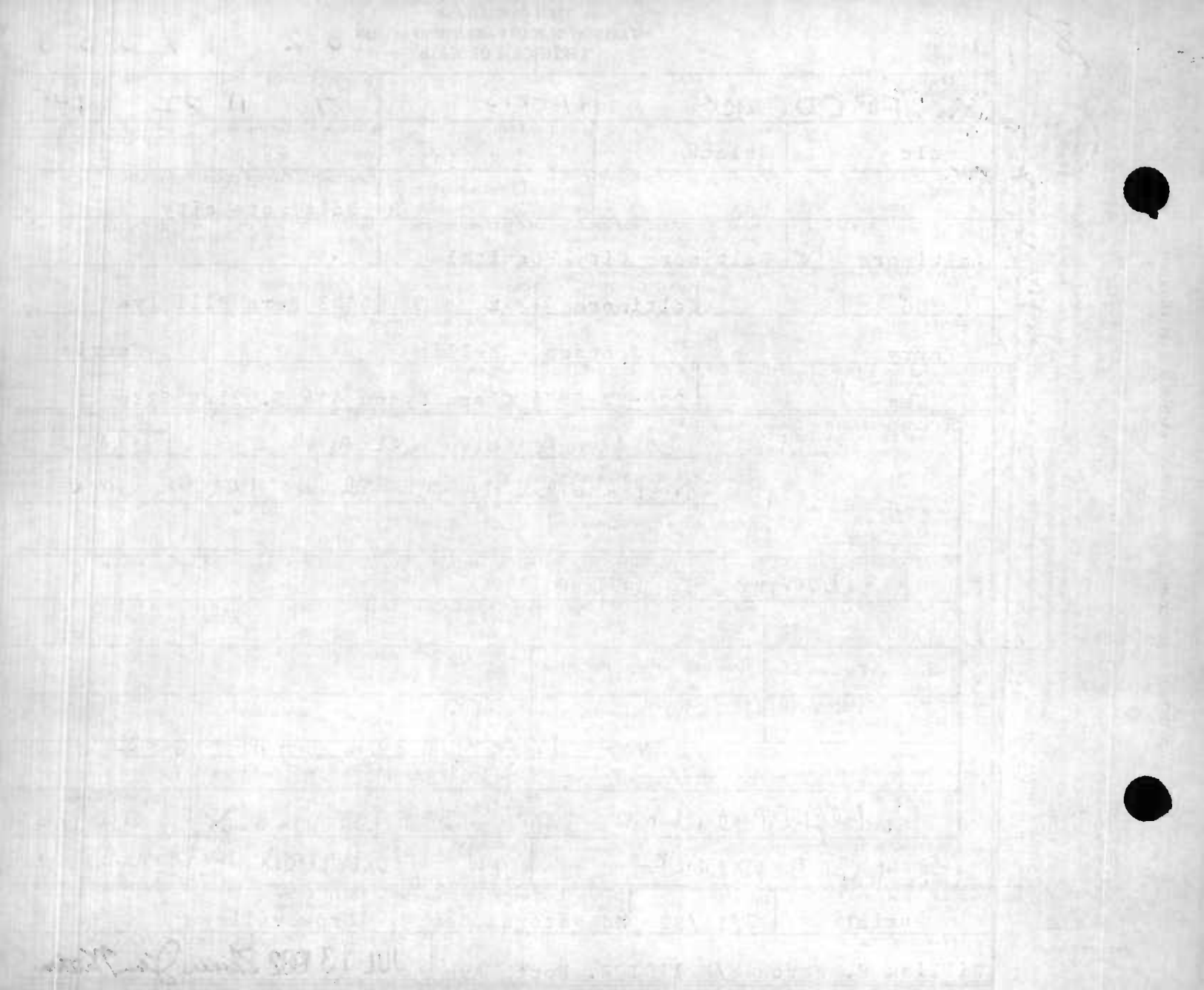
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 6 8

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDERICK HARRIS | | 2a. DATE OF DEATH MONTH DAY YEAR 7 11 82 | | 2b. HOUR 145 M | |
| 3 SEX male | | 4 RACE black | | 5. DATE OF BIRTH MONTH DAY YEAR 8 8 1929 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS 52 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Harry Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Harris | | 13e. STREET ADDRESS 4003 Fern Hill Ave | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 220-22-5874 | | 17 INFORMANT ADDRESS Clara Dyson 414 E. 21st Street | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Disseminated Sgomon Cell Ca of the Lung DUE TO, OR AS A CONSEQUENCE OF (c) 6mm? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) malnutrition, Diabetes mellitus | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/9/82 , 19 82 , to 7/11 , 19 82 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Rudolph E. Merick MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/11/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudolph E. Merick | | | | 22e. ADDRESS 6140 E. Pratt Street, Baltimore Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/16/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md Veteran Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crowsville Md | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 13 1982 Frances Jean Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| LEONARD HARRIS | | | | | JULY 02, 1982 | | | | |
| 3. SEX | | | | | 4. RACE | | | | |
| Male | | | | | Black | | | | |
| 5. DATE OF BIRTH | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | |
| MONTH DAY YEAR | | | | | YRS. | | | | |
| 5 7 24 | | | | | 58 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | |
| N. C. | | | | | U. S. A. | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | |
| BALTIMORE | | | | | THE JOHNS HOPKINS HOSPITAL | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE | | | | | 13b. COUNTY | | | | |
| Md. | | | | | Baltimore | | | | |
| 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| Baltimore | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| Unknown | | | | | Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | |
| No | | | | | 213-16-6989 | | | | |
| 17. INFORMANT | | | | | ADDRESS | | | | |
| Jovita Harris | | | | | 1511 N. Caroline St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cardiorespiratory Arrest | | | | | | | | | |
| 1850 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) Metabolic derangement | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Metastatic prostatic Cancer | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 21b. TIME OF INJURY | | | | | | | | | |
| HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 21f. LOCATION | | | | | | | | | |
| STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | |
| Andrew Beamer | | | | | | | | | |
| DEGREE | | | | | | | | | |
| MD | | | | | | | | | |
| 22c. DATE SIGNED | | | | | | | | | |
| 7/2/82 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| ANDREW BEAMER | | | | | | | | | |
| 22e. ADDRESS | | | | | | | | | |
| Johns Hopkins Hosp Baltimore | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| Burial | | | | | | | | | |
| 23b. DATE | | | | | | | | | |
| 7-7-82 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| Mt. Calvary | | | | | | | | | |
| 23d. LOCATION | | | | | | | | | |
| CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Anne Arundel, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | |
| BEETS F/H 1129 N. Caroline St. | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| JUL 6 1982 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| [Signature] | | | | | | | | | |

MEDICAL CERTIFICATION

219

0807 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 6 7 0 REG. NO. | | | |
|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH HARRISON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 3 82 2b. HOUR 4:55 PM | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR UNKNOWN 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINITAE HEBREW GERIATRIC CENTER + HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4726 DUNCANON RD. 21208 | | 13f. ZIP CODE 21208 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AARON ROSEN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE FRANKLIN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 218-54-2355 17. INFORMANT MRS. LILLIAN BERMAN ADDRESS 4726 DUNCANON RD. BALTO., MD 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7854 IMMEDIATE CAUSE (a) GANGRENE, BOTH FEET, PROGRESSIVE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > ONE MONTH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (we) last saw the deceased alive on _____, 19_____, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. Estrelita DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ESTRELITA O. KUN, M.D. | | 22e. ADDRESS LEVINITAE HEBREW GERIATRIC CENTER + HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BETH ISAAC ADATH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Smith | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical examination must be made.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 6 7 1 REG. NO. | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNARD C. HARRISS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 15 82 | | 2b. HOUR 4:28 PM | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 05 10 33 | | 6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL E.R. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FINANCE OFFICER | | 12b. KIND OF BUSINESS OR INDUSTRY WHOLESALE FOOD | |
| 13a. STATE MARYLAND | | | | 13b. CITY OR TOWN LANSDOWNE | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST EARL C. HARRISS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LEE METTEE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. 212-30-1087 | | 17. INFORMANT EDITH M. HARRISS | | 18. ADDRESS 3001 PUTTY HILL ROAD 21234 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Massive Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) A.S.U.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 years | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:29 82 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6.29 82 to 7.15. 82 , that (I) (we) last saw the deceased alive on 6.29 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Paul Schonfeld M.D. | | | | DEGREE MD | | 22c. DATE SIGNED 7.17.82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL SCHONFELD, M.D. | | | | 22e. ADDRESS 407 CRAIN HIGHWAY SOUTH | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | |
| 25b. REGISTRAR'S SIGNATURE Frances San Martin | | | | | | | |

2

3511 NOT TO BE

UNITED STATES

2000

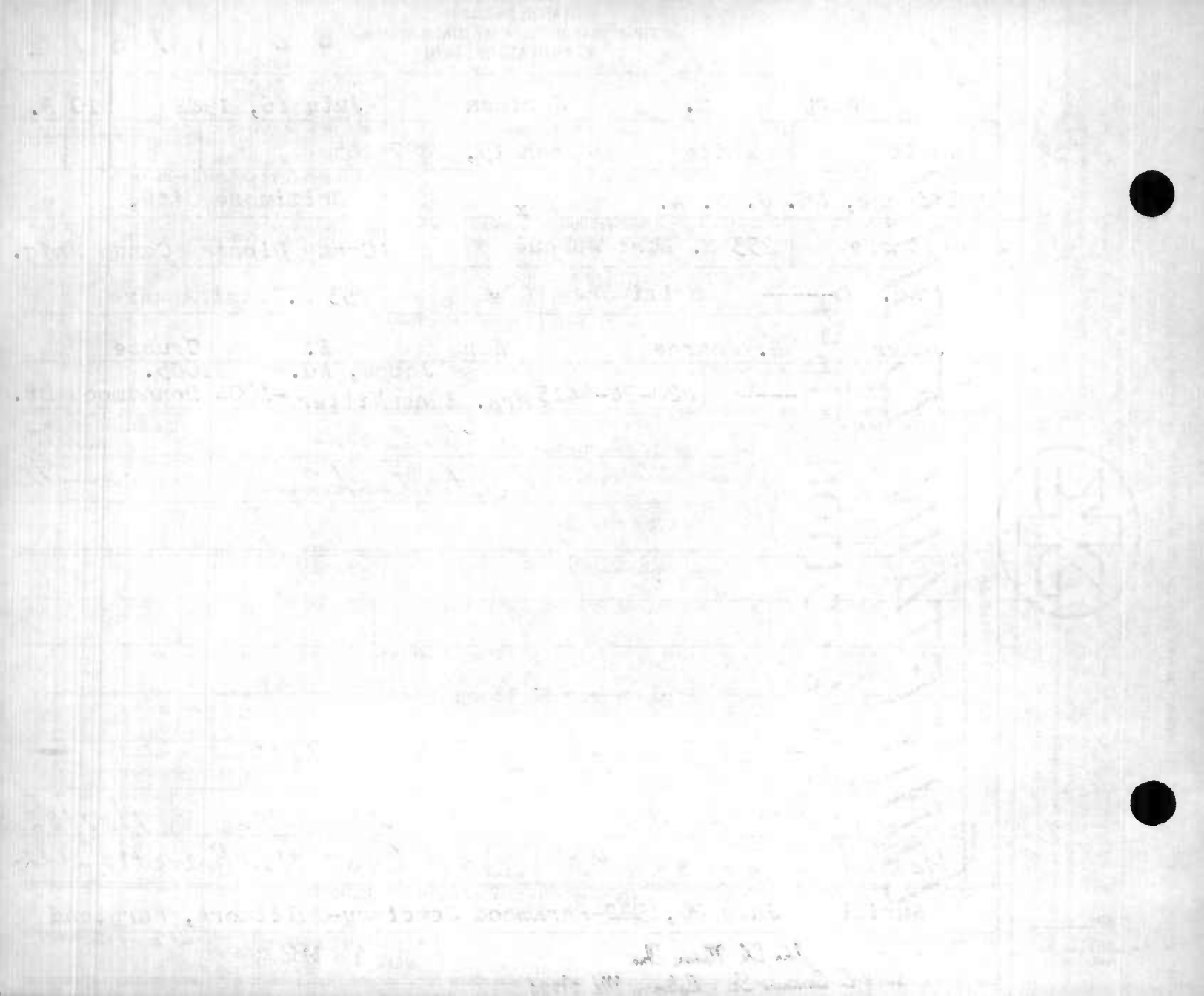
2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 6 7 2 REG. NO. | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 1. DECEASED NAME (TYPE OR PRINT) | | | |
| FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Mary | | E. | | Hartman | | July 16, 1982 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | March 15, 1897 | | 85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Baltimore, Md. | | U. S. A. | | | | Baltimore City, MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 253 S. East Avenue | | Candy Dipper | | Candy Mnfg. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13b. INSIDE CITY LIMITS? | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | |
| Md. | | | | Baltimore | | 253 S. East Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | |
| James M. Monroe | | | | Mary E. Crusse | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | 220-24-9415 | | Joppa, Md. 21085. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon.</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 1 month | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) <u>(husband)</u> attended the deceased from <u>6/1</u> , 19 <u>82</u> , to <u>7/16</u> , 19 <u>82</u> , that (I) <u>(we)</u> saw the deceased alive on <u>7/15</u> , 19 <u>82</u> , and <u>(we)</u> in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did not)</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | |
| <u>Henry J. Houska MD</u> | | | | | | <u>7/17/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| <u>HENRY J. HOUSKA MD</u> | | | | <u>333 S. EAST AVE BALTO MD 21224</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| <u>Burial</u> | | <u>July 20, 1982</u> | | <u>Parkwood Cemetery</u> | | <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>John A. Moran</u> | | | | <u>JUL 19 1982</u> | | <u>John A. Moran</u> | |
| <u>3000 E. Baltimore St. - Baltimore, Md. 21224</u> | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOURSELF. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITH YOURSELF AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 6 7 3 | |
|---|---------|--|---|------------------------|------------------------------------|---|---|--------------------------------------|---|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | MONTH DAY YEAR | | 2b. HOUR |
| William S. Hartman | | | | | | 7 20 1982 | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| male | White | Dec. 8, 1906 | 75 YRS. | MONTHS DAYS HOURS MIN. | | | | 7 21 1982 | | 12:42 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | Baltimore City, | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | 1006 Druidan Court | | | | Mechanic | | Auto. | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| MD. | | | AxAx | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1006 Druidan Ct. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John S. Hartman | | | Catherine Brady | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| no | | | 215-10-0719 A | | Gladys Kroschinsky | | 408 Irene Dr. | | 21061 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease | | | | | | | | | | | |
| 4292 IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | STREET | | | | | |
| 22a. I certify that I took charge of the remains described above, held in death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | |
| Thomas D. Smith | | | M.D. Deputy Chief | | | 7/22/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | | | | |
| Thomas D. Smith, M.D. | | | 111 Penn St. Balto., MD. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | | 23 July 82 | | Loudon Park Cemetery | | | Baltimore | | | MD. |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| James S. Kirkley | | | Glen Burnie MD. | | | JUL 26 1982 | | | Frances Jean Nathan | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 7 4 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 2. DECEASED NAME (TYPE OR PRINT) | | | | REG. NO. | | | |
| HARTZELL, Charles G. | | | | 2e. DATE OF DEATH MONTH DAY YEAR 7/1/82 2b. HOUR 7:00P M | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 1 31 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospt. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Freight Forwarder | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN Balto. | | 13c. INSIDE CITY WANTS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 7001 N. Charles St. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Harry Oscar Hartzell | | | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST Katherine Fogarty | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 293-09-2617 A | | 17. INFORMANT ADDRESS Mr. Charles C. Hartzell, Jr. Bx#5577 Towson | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute resp failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>J. C. BIER</u> MD DEGREE | | | | 22c. DATE SIGNED 7/1/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. C. BIER | |
| 22e. ADDRESS C/O MERCY HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | 23d. LOCATION Balto Co. COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd. 21212 | | | | 25a. RECEIVED BY REGISTRAR 1982 | | | |

1950-1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. 8 2 1 7 6 7 5 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) WALTER P HARVEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 25, 1982 | | 2b. HOUR MIN. 10:15P | | | |
| 3. SEX M | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 4 24 90 | | 6. AGE (IN YEARS LAST BIRTHDAY) 92 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Lumber | | |
| 13a. STATE Md. | | | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES HARVEY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE BOSTON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 212-03-2215 | | 17. INFORMANT ADDRESS Goldie DAVIS 2614 E. PRESTON ST | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Bundle Branch Block ≥ 7 years DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease ≥ 8 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12-24-77 , 19 77 , to 7-25 , 19 82 , that (I) (we) last saw the deceased alive on 5-18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Eugene H. Owens M.D. | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7-27-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene H. Owens | | | | | 22e. ADDRESS 1735 E. Federal St Balto. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Balto Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto Md. | | | |
| 24. FUNERAL DIRECTOR NAME Locks Funeral Home 1804 N. Calver | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE James Jean Warren | | | | | |

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FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 6 7 6
REG. NO.

| | | | | |
|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ANNA U. HAWKINS | | | 2a. DATE OF DEATH 7 MONTH 5 YEAR 82 2b. HOUR 1P20 M | |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH 12 DAY 20 YEAR 25 | 6. AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS. | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | 13b. COUNTY BALTIMORE | 13c. CITY OR TOWN BALTIMORE | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 3509 WOODLAN AVE. |
| 14. FATHER'S NAME FIRST CHARLES MIDDLE A. LAST HAWKINS | | 15. MOTHER'S MAIDEN NAME FIRST LENA MIDDLE BRISCOE LAST BRISCOE | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 1 (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO 215-22-438 | | |
| 17. INFORMANT ANNA HAWKINS (PER REGISTRATION RECORD) | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAL ARREST 1509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) EXSANGUINATION DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED CANCER OF ESOPHAGUS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINS 24-36 HOURS MONTHS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NONE | | | | |
| 19a. DATE OF OPERATION 5/18/82 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRAUMED - GROW CHITZ FISTULA 2° CANCER | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/24/82 , 19 82 , to 7/13/82 , 19 82 , that (we) lost saw the deceased alive on 7/13/82 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Michael W. Brown | DEGREE MD | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 7/13/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL W. BROWN | | 22e. ADDRESS UNIV. OF MD HOSP. 22 S. GREENE ST. | | |
| 23a. BURIAL, CREMATION, REMOVAL (BY WHOM) BURIAL | 23b. DATE 7/8/82 | 23c. NAME OF CEMETERY OR CREMATORY ST JOSEPH CATH. CEMETERY | 23d. LOCATION (CITY OR TOWN) COUNTY STATE POMFRET MD | |
| 24. FUNERAL DIRECTOR NAME Marshall & Sons | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | REGISTRAR'S SIGNATURE Frances Jan. Nathan | |

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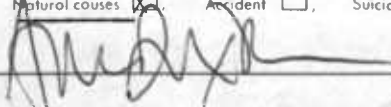
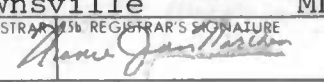
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Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17677 | |
|--|-------------------------|---|--|---|---|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORLETHA V. HAYES | | | | | | | | | | 2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 4 1982 | |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 3 3 18 | | 6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS. | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 4 1982 | | 2d. HOUR 12:52 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2328 Edmondson Avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Anderson Williams | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Price | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 220-03-1067 | | 17. INFORMANT ADDRESS Robert Hayes 2328 Edmondson Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | TITLE (SPECIFY) Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED 7-5-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE  | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

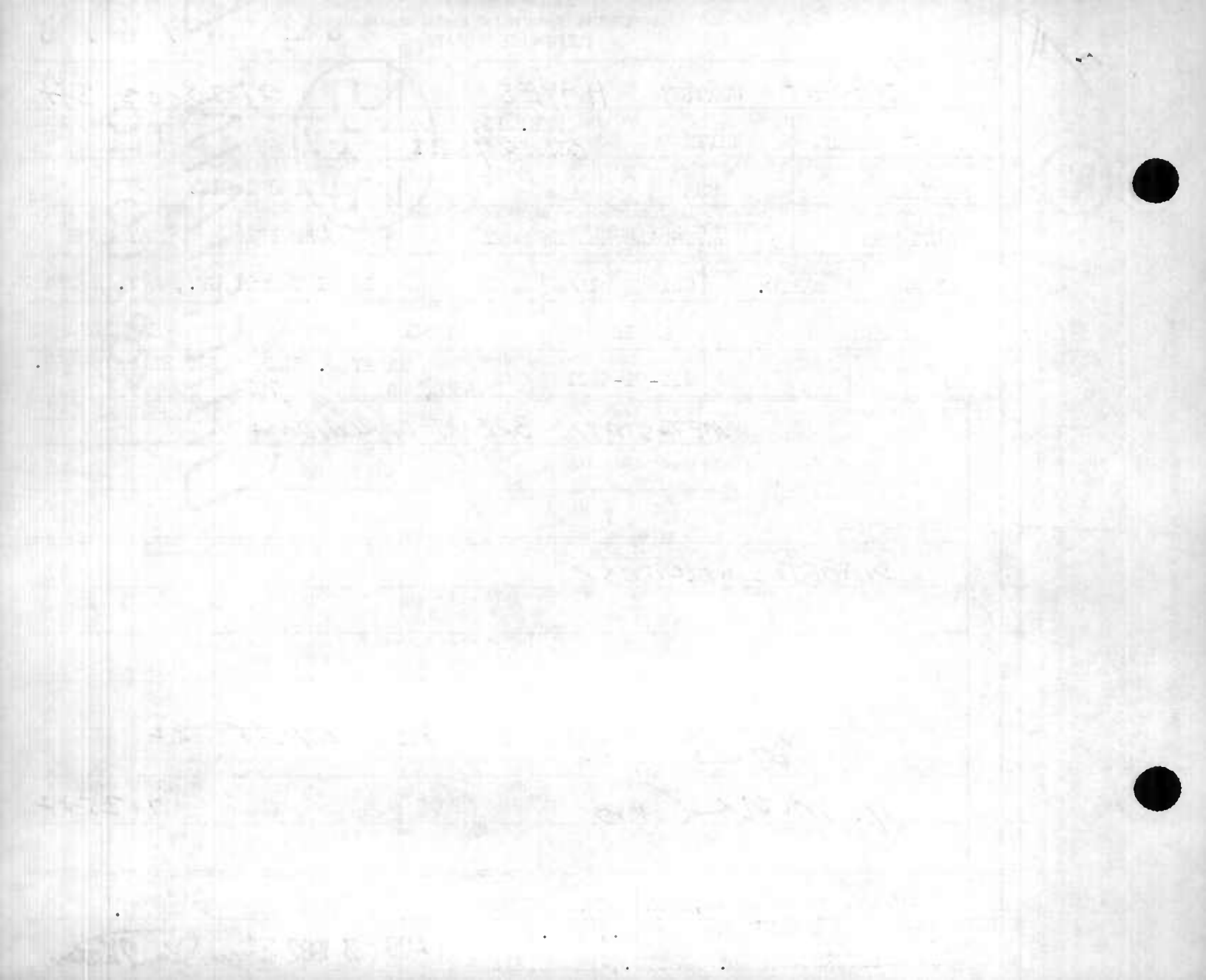
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 7 8
REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH DOROTHY HAYES | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-25-82 | | 2b. HOUR 5:45 M |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 01-13-1914 | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | IF UNDER 1 YEAR MONTHS DAYS |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME |
| 13a. STATE MARYLAND | 13b. COUNTY BALTO. | 13c. CITY OR TOWN OWINGS MILLS | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 16 BITTERROOT CT., APT. E 21117 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HENRY LURIE | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE SAMUELSON | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-01-4621 | | 17. INFORMANT ADDRESS BARRY I. BLUM 340 ELLERTON SO. LAUREL, MD 20707 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 07-09 , 19 82 , to 07-25 , 19 82 , that (I) (we) lost saw the deceased alive on 07-25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE A. M. N. M. | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7-25-82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 28, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY ANSHE NIESEN | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD | | 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE AUG - 3 1982 James J. Thornton | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|--|---|---|--|--------------------------------------|--|--|------------------------------|
| 1. FOR STATE REGISTRAR | | | | | 7 2 1 7 6 7 9 | | | | | |
| CERTIFICATE OF DEATH | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Benjamin H Heath | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 17, 1982 | | | | | 2b. HOUR 6:30 P.M. |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12-24-87 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Woodlawn | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Heath | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Reid | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W 1 | | 17. INFORMANT Mrs. Mary H. Miller | | 16412 | | 104 Valley View Drive Edinboro, Pa. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 20, 19 82 , to July 17, 19 82 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on July 17, 19 82 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not see the body after death. | | | | | | | | | | |
| 22b. SIGNATURE E J McDonnell Jr. | | | | | DEGREE | | 22c. DATE SIGNED 7/17/82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E J McDonnell Jr. | | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-20-82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, MD. 21133 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | | |

WASHINGTON, D.C.
JULY 17, 1952

July 17, 1952

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Washington General Hospital

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Washington General Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1503 BP

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|--|--|---------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Richard R. Heath Jr. | | | | | | | | 7 3 82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Male | | Black | | 9 28 22 | | 59 | | 6 35 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY OR COUNTY OF DEATH | |
| VA | | USA | | | | Baltimore City | | MD | |
| 11. CITY OR TOWN OF DEATH | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 14. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Baltimore City Hospital | | | | | | | |
| 15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 15b. STATE | | 15c. COUNTY | | 15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15e. STREET ADDRESS | |
| MD | | | | Baltimore | | | | 1605 N. Warwick Avenue | |
| 16. FATHER'S NAME FIRST MIDDLE LAST | | 17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 19. SOCIAL SECURITY NO. | | 20. INFORMANT ADDRESS | |
| Richard R. Heath Sr. | | Maryland Hilton | | Yes | | 214-12-1975 | | Helen M. Heath 1605 N. Warwick Ave. | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Cardio primary arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>hemoptysis + aortic</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>...</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 22a. DATE OF OPERATION | | | | | | | | | |
| 22b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 22c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 22d. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 23d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | |
| 23e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | |
| 23f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 24. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>82</u> , to <u>July 3</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>July 3</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 25a. SIGNATURE DEGREE | | | | | | | | | |
| 25b. DATE SIGNED | | | | | | | | | |
| 25c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | |
| 25d. ADDRESS | | | | | | | | | |
| 26a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | |
| 26b. DATE | | | | | | | | | |
| 26c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | |
| 26d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 27. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | | |
| 28a. DATE REC'D. BY REGISTRAR | | | | | | | | | |
| 28b. REGISTRAR'S SIGNATURE | | | | | | | | | |

JUL 6 1982

Bruce Kinsman

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) Francis E. Heffernan | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 5, 1982 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 17, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5509 Greenfield Avenue | | | | 12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE Transit Co. Painter | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5509 Greenfield Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Heffernan | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Kearney | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 213-10-0412 | | 17. INFORMANT ADDRESS Mrs. Josephine C. Thomas 7826 Eastdale Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic adenocarcinoma of the stomach 1519 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. ASCD c recent M.I (7/82) and ventric. ectopy | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 6/22 1982 to 6/22 1982 , that (I) saw the deceased alive on 6/22 1982 , and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN Philip F. Bronowitz MD | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip F. Bronowitz MD | | | | 22e. ADDRESS 2435 W. Belvedere Ave Balto. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 8, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Smith | | | |

1. The first part of the report

is a general introduction to the subject

and

the

second

part

of the report

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 8 2 | | | |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| IRENE AUGUSTA DEUTERMANN HEIDER <i>Irene D. Heider</i> | | | | 7-1-82 6 ⁴⁰ -A ^M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Caucasian | | 4-24-03 | | 79 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Wash., D.C. | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 2423 Pickwick Rd. | | Retired | | Agriculture | |
| 13. USUAL RESIDENCE (IF MARKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. CITY OR TOWN | | 13b. STREET ADDRESS | |
| Florida | | | | Pompano Beach | | 1012 N. Ocean Boulevard | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| Frank Deutermann | | Batherine Kahlert | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| NO | | 217-44-6174 | | CARLA HEIDER ROSENZWEIG 2423 PICKWICK RD., BALTO., MD. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) adenocarcinoma of lungs DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (she/he/it) attended the deceased from July 19 81, to July 1, 19 82, that (I) (we) last saw the deceased alive on June 3, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | 22d. ADDRESS | | 22e. DATE SIGNED | |
| Michael B. Stewart, M.D. | | M.D. | | Baltimore Cancer Research Center 22 S. Greene St. Balto., Md. 21201 | | 7/1/82 | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22g. ADDRESS | | | | | |
| MICHAEL B. STEWART, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY MARYLAND | |
| CREMATION | | 7/2/1982 | | GREEN MOUNT CREMATORY | | BALTIMORE | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| WALTER BROOKS BRADLEY INC., BALTO., MD. 21222 | | | | JUL 8 1982 | | Frances Jan Kithen | |

14



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17583 | |
|--|---------------|--|--|---|--|--|---|--|----------------------------------|--|--|
| 1- FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) George A Helfer | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 7 23 82 | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 16 1909 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 72 | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD 7 23 82 | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 N. Belnord | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Bagby Furn. | | | |
| 13a. STATE Maryland | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 509 N. Belnord Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Stephen Helfer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Swartz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. 215 18 0990 | | 17. INFORMANT ADDRESS Theresa Appelt 509 N. Belnord Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Carcinomatosis, primary unknown | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H. R. Guard</i> | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7/23/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Balto. MD 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE July 26 '82 | | 23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 700 S. Conkling St. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE <i>Francis J. Nathan</i> | | | |

RECEIVED

U.S. DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

[Handwritten signature]

[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]

RELEASED BY MEDICAL EXAMINER ON APPROVAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified only once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 6 8 4 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Walter | | MIDDLE A. | | LAST Heline | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| Heline Walter Heline | | | | | | | | 7/24/82 | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6. AGE IN YEARS LAST BIRTHDAY | | 7b. HOUR | |
| MALE | | CAUC. | | 8 20 43 | | 38 | | 7 P.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | 10. MONTHS DAYS HOURS MIN. | |
| Maryland | | USA | | | | Baltimore City | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. City | | Balto. City Hospital | | Engineer-Dept. Public Works | | Balto. City | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| Md | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1211 Limit Avenue | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Albert Henry Heline | | Margaret Louise Warfield | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | | |
| No | | 219-42-9595 | | Margaret L. Heline | | 3504 Wheelhouse Rd. | | | |
| | | | | Balto., MD. | | 21220 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | IMMEDIATE CAUSE (a) | | Cardiac Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 1 hr. | |
| 8903 | | DUE TO, OR AS A CONSEQUENCE OF | | Vasculature Derangement | | | | 12 hr. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | 72.5% TBSA 3° Burns | | | | 12 hr. | |
| | | (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | 6 P.M. 7/24 1982 | | House Fire | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | Home | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 24 1982 to July 24 1982 that (I) (we) lost saw the deceased alive on July 24 1982 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Donald S. Weinstein, M.D. | | M.D. | | | | 7/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| Donald S. Weinstein, M.D. | | Balto. Regional Burn Ctr, Balto. City Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 7/29/1982 | | Gardens Of Faith | | Baltimore Maryland | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Duda-Ruck, Inc | | 7922 Wise Avenue Dundalk, MD. 21222 | | JUL 28 1982 | | [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 6 8 5 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES BARBARA HENNESSIE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 7 82 | | 2b. HOUR 6 30 P.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Weaver | | 12b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Woodlawn | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2117 Lorraine Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William A. Luers | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence M. Keck | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Michael J. Hennessie, 1681 Woodstock Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Autocerebral bleed DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/3/82 , 19 82 , to 7/7 , 19 82 , that (I) (we) last saw the deceased alive on 7/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Michael J. Hennessie | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. MACHADO MD. | | | | 22e. ADDRESS ST Agnes Hospital BACT. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/82 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Witzke Catonsville Funeral Home, P.A. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 8 1982 Frances Jean Nathan | | | |



7 7 1 2 2

STANDARD HONORARY

Feb. 2, 1902

23

Baltimore City

x

U.S.A.

Perkins

St. Johns Hospital

Baltimore

Power

1177 Locust Ave.

x

Colony T. Robinson

Perkins

Florida

Albany

A.

Willie

March 2, 1902, 1004 Woodstock St.



101 - 2182 - 101
John J. ...

101 - 2182 - 101
John J. ...

3
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 11b shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 6 8 6 REG. NO. | | | |
|--|--|--------------|---|---|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Dixon Hepperle sr. | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 1 82 | | | | 2b. HOUR 325 PM | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 3 - 8 - 03 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | 10. CITY OR TOWN OF DEATH Baltimore | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard | | 12b. KIND OF BUSINESS OR INDUSTRY School Construction | |
| 13a. STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 3207 Lorena Avenue 21227 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Hepperle | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma M. Mailey | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 205-09-8333 | | 17. INFORMANT ADDRESS Emily M. Hepperle--Same as 13e | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (c) Oat Cell lung Cancer with metastasis to brain APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from 6-26-1982 to 7-1-1982, that (I) saw the deceased alive on 7-1-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.) | | | | | | | | | | | | | |
| 22b. SIGNATURE Edwin E. Pagan | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7-1-82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin E. Pagan | | | | | | 22e. ADDRESS 3041 South Hanover st. Baltimore Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 7/2/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Nuthen | | | | | |

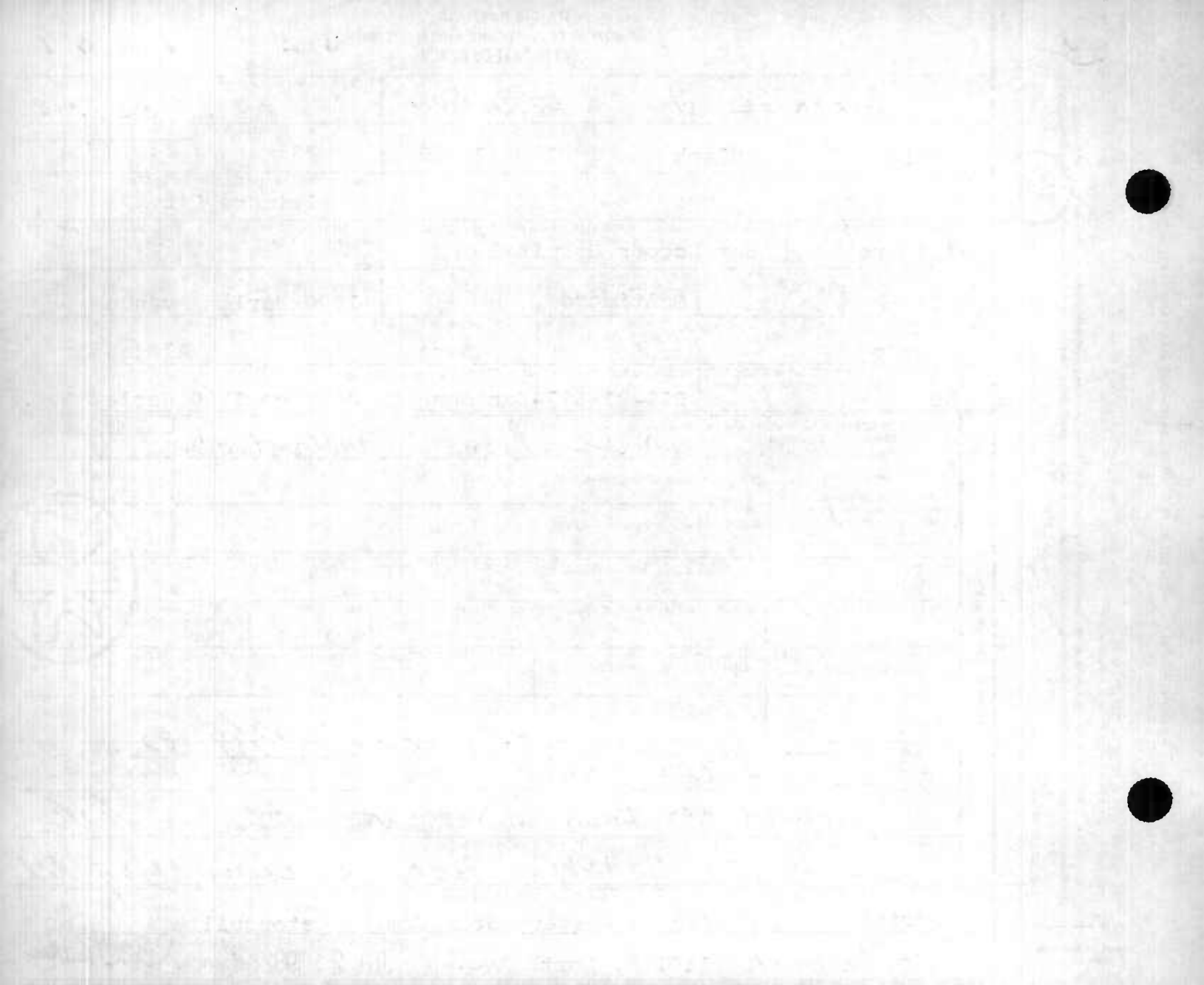


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 6 8 7 REG. NO. | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | |
| Male | | | | | | | | | | Black | | | | 2 22 09 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| S.C. | | | | | | | | | | USA | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Baltimore | | | | | | | | | | USA | | | | Baltimore City | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| Baltimore | | | | | | | | | | Bon Secour Hospital | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| MD | | | | | | | | | | | | | | Baltimore | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | 13d. INSIDE CITY LIMITS? | | | |
| Wade | | | | | | | | | | Herndon | | | | Sarah | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| No | | | | | | | | | | 219-01-6174 | | | | Earldene R. Johnson | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS | | | |
| IMMEDIATE CAUSE (a) 1629 CA of lung c metastasis | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 1900 Harlem Avenue | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | | | (b) | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | |
| | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION | | | |
| | | | | | | | | | | | | | | CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 06/01/82 to 07/17/82, that (I) (we) lost saw the deceased alive on 7/16/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Kuang-yen Huang M.D. | | | | | | | | | | ATTENDING MEDICAL STAFF | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | |
| KUANG-YEN HUANG | | | | | | | | | | BON Secours Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | | | | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | | | | | | | 7/22/82 | | | | Western Star Cem. | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 23d. LOCATION | | | | 23e. DATE REC'D. BY REGISTRAR | | | |
| Wm. C. March F/H 1101 E. North Ave. | | | | | | | | | | Catonville | | | | JUL 21 1982 | | | |
| NAME | | | | | | | | | | ADDRESS | | | | REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | | | | | | | Frances Jan Nathan | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17688

| | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2. DATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Joe Dan Herring | | | | | | | | | | 2. DATE OF DEATH 7 17 82 | | | | | | | | | |
| 3. SEX Male 4. RACE Black 5. DATE OF BIRTH 9 14 56 6. AGE (IN YEARS) 25 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. MONTH DAY YEAR 7 17 82 9. BALTIMORE CITY OR COUNTY OF DEATH AM | | | | | | | | | | 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1119 Whitelock Street 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 13. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 13a. STATE MD 13b. COUNTY Baltimore 13c. INSIDE CITY LIMITS? YES NO 13d. STREET ADDRESS 1119 Whitelock St. | | | | | | | | | | 14. FATHER'S NAME William Ernest Herring 15. MOTHER'S MAIDEN NAME Thelma Stevens | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16b. SOCIAL SECURITY NO. N/A 17. INFORMANT Mr. & Mrs. William Herring | | | | | | | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: Seizure Disorder 7803 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO XX | | | | | | | | | | 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | 22a. I certify that I took charge of the remains described above, held on Autopsy , Inspection XX , Inquiry , and in my opinion death resulted from: Natural causes XX , Accident , Suicide , Homicide , Undetermined manner . | | | | | | | | | |
| ACTUAL SIGNATURE Hormez R. Guard M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7/17/82 | | | | | | | | | | EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7/24/82 23c. NAME OF CEMETERY OR CREMATORY King Mem. Park 23d. LOCATION Baltimore COUNTY Co. STATE MD | | | | | | | | | | 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 25b. REGISTRAR'S SIGNATURE Frances Ann Nathan | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 6 8 9
REG. NO.

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GEORGE E. HESS | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 4 1982 | | | 2b. HOUR 9:35A M | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR MAY 27 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Man | | 12b. KIND OF BUSINESS OR INDUSTRY Board of Education | |
| 13a. STATE MARYLAND | | 13b. COUNTY HARFORD | | 13c. CITY OR TOWN EDGEWOOD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 1934 SIDNEE DR. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Hess | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lou Bicey Brummett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 235-30-9329 | | 17. INFORMANT MRS. HESS | | ADDRESS 1934 SIDNEE DR. EDGEWOOD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1629 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) was did attend the deceased from JULY 01 , 19 82 , to JULY 4 , 19 82 , that (I) was did saw the deceased alive on JULY 4 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Thomas S. Miller, md | | | | DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED JULY 4, 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER | | | | 22e. ADDRESS GOOD SAMARITAN HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (PRINT) Burial | | 23b. DATE 7/9/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md. | | | |
| 24. FUNERAL DIRECTOR Brazdzinski Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Miller | | | |
| 26. ADDRESS PA 1407 Old Eastern Ave. | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| 1- FOR STATE REGISTRAR | | STATE OF MARYLAND | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | REG. NO. 17690 | |
|---|--|--|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | Katherine Angela Hester | | 2b. DATE OF DEATH | | KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR | | 7 29 19 82 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 24 HRS. | |
| Female | | White | | 11 23 19 | | 62 YRS. | | 8:05 P.M. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | Baltimore | |
| Baltimore | | 1225 Wellsback Avenue | | Housework | | At Home | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1225 Wellsback Avenue | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| John | | Marie | | No | | | | Mary Kerner 8101 Shore Road 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 9654 | | IMMEDIATE CAUSE (a) Multiple Gunshot Wounds (unspecified) | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | 8:00 P.M. 7 29 19 82 | | subject was shot | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY STATE | |
| | | Home | | 1225 Wellsback Ave., Baltimore, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | TITLE (SPECIFY) | | DATE SIGNED | | | |
| ACTUAL SIGNATURE | | M.D. Assistant | | MEDICAL EXAMINER | | 7-30-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Hormez R. Guard, M.D. | | ADDRESS | | 111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | COUNTY STATE | |
| Cremation | | 7-31-82 | | Westview Mem. Park | | Westview Balto. Co. Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR SIGNATURE | | | | | |
| NAME ADDRESS | | AUG - 2 1982 | | Name J. [Signature] | | | | | |
| C.S. Zeiler & Son Inc. 6224 Eastern Avenue | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|---|---------------------------|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| REG. NO. | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA HIGGINS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-27-82 | | | | | 2b. HOUR 8:35 M |
| 3. SEX FEMALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 4-13-94 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stattie | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Saphemia Redd 5111 Levinville Rd | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | | | | | | | | |
| 22b. SIGNATURE Gregory F. McAuliffe MD | | | | | DEGREE MD | | | 22c. DATE SIGNED 7-27-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory F. McAuliffe MD | | | | | 22e. ADDRESS 900 Caton Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD | | | | |
| 24. FUNERAL DIRECTOR NAME Vernon R. Bailey | | | | | ADDRESS 1348 N. Calhoun St. | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Frances Jean Warren | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME (TYPE OR PRINT) WILLIAM SR. HILDEBRAND | | | 2a DATE OF DEATH MONTH 7 DAY 24 YEAR 82 | | | 2b HOUR 12 25 P.M. | | | | | |
| 3 SEX M | | 4 RACE W | | 5 DATE OF BIRTH MONTH 11 DAY 30 YEAR 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD. | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF MORE THAN ONE, GIVE STREET ADDRESS) South Baltimore 6th | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Rigger | | | 12b. KIND OF BUSINESS OR INDUSTRY 4 | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. CITY OR TOWN Baltimore | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS 1513 Marshall St | | | | | |
| 14 FATHER'S NAME FIRST Harry MIDDLE Hildebrand | | | | 15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE Hemstrate | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b SOCIAL SECURITY NO. 243019490A | | 17. INFORMANT Harry (wife) | | | | ADDRESS Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5621 IMMEDIATE CAUSE (a) Septic SHOCK. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FOREIGN BODY PERFORATION OF SIGMOID COLON | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (1) DIVERTICULOSIS (2) LYMPHOMA | | | | | | | | | | | |
| 19a DATE OF OPERATION 7/10/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED COLON PERFORATION | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from 6/28/82 to 7/24/82 , that (1) we last saw the deceased alive on 7/24/82 , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) we did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. Calderon | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE CALDERON | | | | 22e ADDRESS SOUTH BALTIMORE G.H. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b DATE 7/27/82 | | 23c NAME OF CEMETERY OR CREMATORY Glen Haven Men. Park | | 23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie MD | | | |
| 24 FUNERAL DIRECTOR McMully Funeral Home | | | | | | ADDRESS 130 E. Font Ave. | | 25a DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b REGISTRAR'S SIGNATURE James J. [Signature] | |

WILLIAM B. HINDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <div> 1- FOR STATE REGISTRAR </div> <div> CERTIFICATE OF DEATH </div> <div> 8 2 1 7 6 9 3 </div> </div> | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel H111 | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 16 82 7b. HOUR 5:45P M | | | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6 7 32 | | 6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Stanley | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Wallace | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Jean Stanley 1100 Bolton St. Balto., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <div style="display: flex;"> <div style="flex: 1;"> PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ovarian Carcinoma</u> 1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last </div> <div style="flex: 1;"> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) </div> </div> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Right Lung Abscess</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 16, 1982</u> to <u>July 16, 1982</u> that (I) (we) last saw the deceased alive on <u>July 16, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Davis M Hahn | | | | | 22c. DATE SIGNED 7/16/82 | | | 22d. ADDRESS 5801 Loch Raven Blvd 21230 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HGTS. AVE. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | | | | |

12/10/04
100 X 104

14

100 X 104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, in the Department of Health, should be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|--|-----------------------------|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 2 1 7 6 9 4 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| KENNETH HILL | | | | | 7 9 82 3:30 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| Male | | White | | 6/21/03 | | 79 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Connecticut | | U.S.A. | | | | Baltimore City MD | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | Union Memorial Hospital | | | | Executive | | Hill Stapler | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | | | |
| 13a. STATE COUNTY CITY OR TOWN | | | | | 13b. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| Maryland Baltimore Towson | | | | | 13c. STREET ADDRESS | | | | |
| | | | | | 604 Dunkirk Rd. | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| William Martin Hill | | | | | Anna Elizabeth Squires | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| No | | | | | 578-28-2473 | | Evelyn Hill 604 Dunkirk Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| 4310 IMMEDIATE CAUSE (a) Hemorrhage, Acute, Posterior Cerebral | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary Arteriosclerosis, Diabetes Mellitus, Chronic Azotemia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 63 to 7-9-19 82, that (I) (we) saw the deceased alive on 5-2-19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | | | |
| William P. Benson, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7-9-82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| William Benson | | Union Memorial Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Cremation | | 7/10/82 | | Westview | | Catonsville, Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | | | |
| Ambrose, Inc. | | 1328 Sulphur Spring Rd. | | JUL 13 1982 Charles J. Nathan | | | | | |

BP

1901

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1908

1909

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1911

VOIDED DEATH CERTIFICATE NUMBER

82-17695 --- See 1981 Deaths Late 81-33504

Shirley M. Hill, July 15, 1981 - City

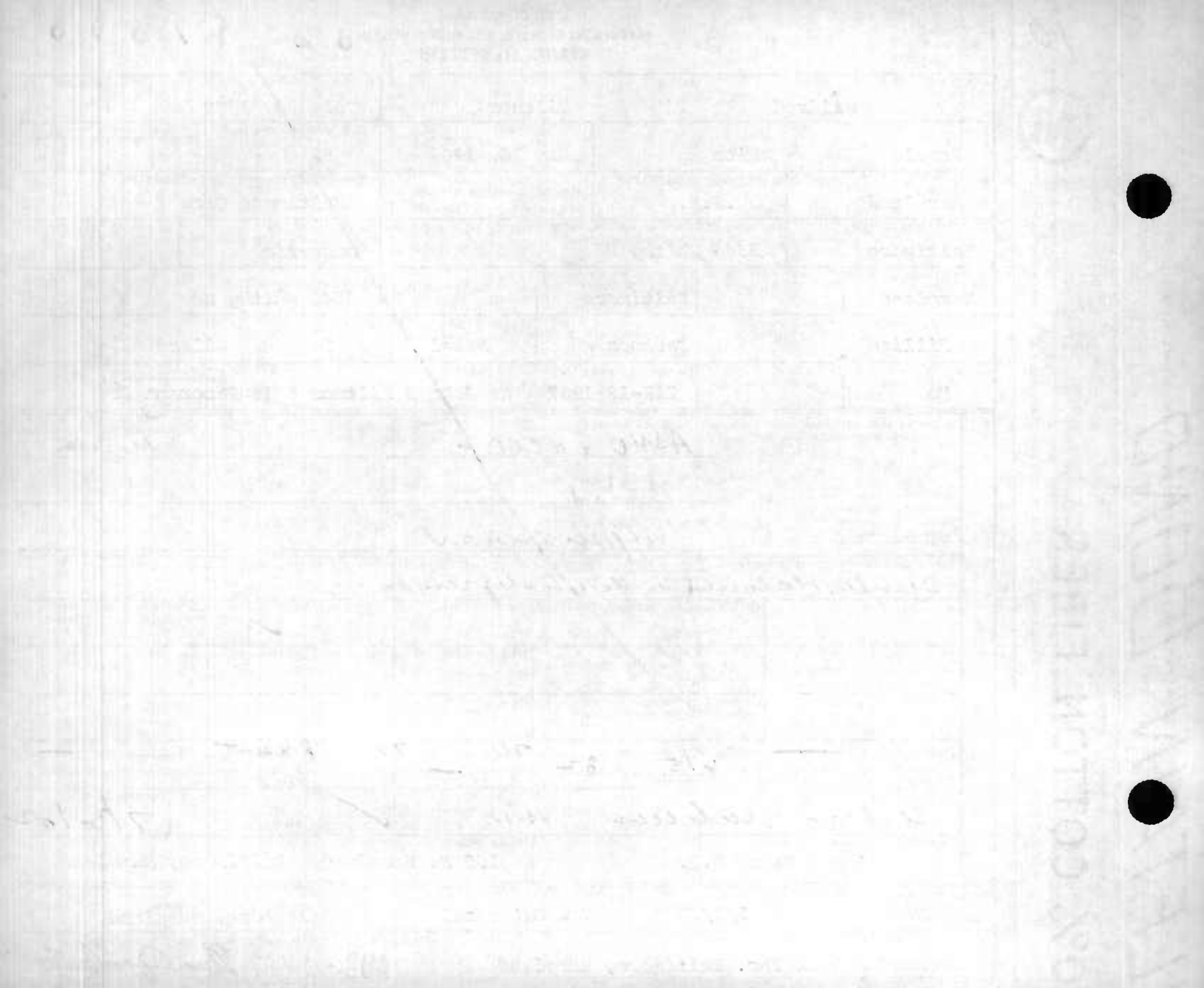


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

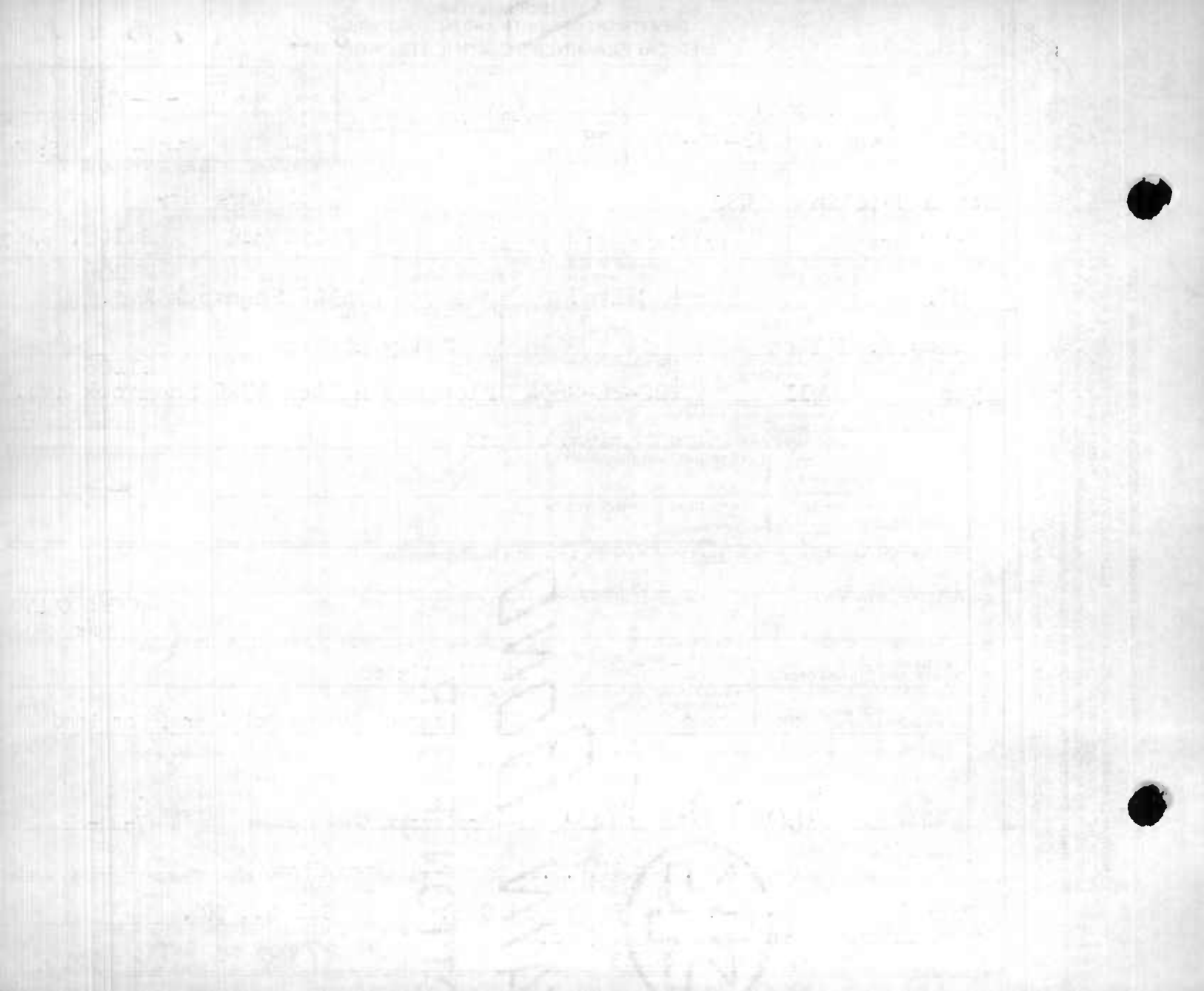
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 7 2 1 7 6 9 6 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| Mildred I Hiltner | | | | | July 29, 1982 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | |
| Female | | White | | May 20, 1900 | | 82 | | M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore City | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 5546 Whitby Rd | | | | Housewife | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? | | | | |
| 13a. STATE Maryland | | | | | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 13b. COUNTY | | 13c. CITY OR TOWN | | 13e. STREET ADDRESS | | | | | |
| | | Baltimore | | 5546 Whitby Rd | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | |
| 14. FIRST MIDDLE LAST William A Jackson | | | | | 15. FIRST MIDDLE LAST Mabel L Allard | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 217-18-1967 | | Mr John E Hiltner 6516 Panorama Dr Eldersburg, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) 4140 ASHD + HCUO - | | | | | | | | | Months |
| DUE TO, OR AS A CONSEQUENCE OF (b) AS. | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| Diabetes, Malnutrition due to depression | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1, 19 77, to present, 19 82, that (I) (we) last saw the deceased alive on 6/5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | |
| Albert Nahum | | | | M.D. | | | | 7/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| Albert Nahum M.D. | | | | 100 N. Broadway Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 8/2/82 | | New Cathedral | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME Leonard J Ruck Inc. Baltimore, Maryland | | | | ADDRESS | | AUG - 2 1982 | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17697 | |
|---|--|------------------|---|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST RUSSELL | | | MIDDLE HILTON | | | LAST | | |
| 2a. DATE KNOWN OF DEATH | | | XX MONTH DAY YEAR | | | 7-19-82 | | | 7b. HOUR M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS) 78 YRS. | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 7-19-82 8:04P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK) Policeman | | 12b. KIND OF BUSINESS OR INDUSTRY Balto. City | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 21206 4322 Shamrock Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Amos W. Hilton | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Hartsoe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. WWII 220-24-8854 | | 17. INFORMANT ADDRESS 21206 Florence Hilton 4322 Shamrock Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 19c. HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. TIME OF INJURY 7PM 7-19-82 P.M. | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 20f. LOCATION STREET CITY OR TOWN COUNTY STATE 4322 Shamrock Avenue Baltimore, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7-20-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | |
| 24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 27 1982 | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, a medical examiner must be notified before burial or cremation.

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|---|--|---|--|---|---|---|---------------------------------------|-----------------------------------|--|--|
| 1- STATE REGISTRAR | | | | | 8 2 1 7 6 9 8 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| NORMAN FREDERICK HIMMELMAN | | | | | JULY 4, 1982 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Male | | White | | 4 30 15 | | 67 YRS | | 11:48A.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Baltimore, Md. | | U.S.A. | | | | Baltimore City | | MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | Church Hospital | | | | Retired | | Amer. Smelt-Ref. | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Maryland | | Baltimore | | Eastwood | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 7221 Gough Street 21224 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Charles HIMMELMAN | | | | | Florence HENNINGAN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| No | | | | | 213-01-0271 | | Maryellen Himmelman 7221 Gough Street | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | |
| 4292 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| CHRONIC OBSTRUCTIVE PULMONARY DISEASE; PNEUMONIA; RESPIRATORY FAILURE; | | | | | | | | | | |
| DIABETES MELLITUS; AORTOILIAC AND BIFEMORAL THROMBOEMBOLIC FEMORAL BYPASS | | | | | | | | | | |
| 19. DATE OF OPERATION | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21a. HOW INJURED | | 21b. IF YES, WERE WOUNDS USED IN CERTIFYING CAUSES | | 21c. NO <input type="checkbox"/> | | |
| MAY 8, 1982 | | AORTOILIAC OCCLUSION | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 3, 19 82, to JULY 4, 19 82, that (I) (we) last saw the deceased alive on JULY 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | 22c. DATE SIGNED | | | |
| AHMED F. NOUR, MD. | | | | | MD | | JULY 4, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| | | | | | CHURCH HOSPITAL CORPORATION 100 N. BROADWAY, BALTIMORE, MARYLAND 21231 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 7-8-82 | | Oak Lawn Cemetery | | Eastwood, Balto. Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25. DATE REC'D. BY REGISTRAR | | | | | |
| C.S. Zeiler & Son Inc. 6224 Eastern Avenue | | | | | JUL 6 1982 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 6 9 9 | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | |
| I. DECEASED NAME | | | | | | | | | | 2a. DATE OF DEATH | |
| [TYPE OR PRINT] FIRST MIDDLE LAST | | | | | | | | | | MONTH DAY YEAR | |
| HENRY P. HIMPLER SR. | | | | | | | | | | July 12 82 | |
| 3 SEX male | | | | | | | | | | 2b. HOUR 8:10 AM | |
| 4 RACE white | | | | | | | | | | 5. DATE OF BIRTH | |
| 5. DATE OF BIRTH MONTH DAY YEAR | | | | | | | | | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 2 MONTH 19 06 | | | | | | | | | | 76 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brookland, N. Y. | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | | | | | | | | BALTO. CITY MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) steel worker | |
| 12b. KIND OF BUSINESS OR INDUSTRY Local 16 | | | | | | | | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. CITY OR TOWN Rosedale | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS | |
| 13e. STREET ADDRESS 5913 Daybreak Terr. | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Himpler, Sr. | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Wag | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | | | | | | | 16b. SOCIAL SECURITY NO. 144-01-5280 | |
| 17. INFORMANT ADDRESS | | | | | | | | | | Murial Lundy, 5913 Daybreak Ter. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 5679 IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | | | | | | | 10 MINUTES | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE ORGAN FAILURE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) PERITONEAL LUNG AND WOUND INFECTION | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PERIPHERAL VASCULAR DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 3 19 82, to JULY 12 19 82, that (I) (we) lost saw the deceased alive on JULY 12 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Michael Shear MD | | | | | | | | | | 22c. DATE SIGNED 7/12/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SHEAR | | | | | | | | | | 22e. ADDRESS 2407 MARYLAND AVE. 21218 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | | | | | | 23b. DATE 7-14-82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Belair Mem. Gardens | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 23e. LOCATION CITY OR TOWN COUNTY STATE Belair Harford Co., Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Isaacson R. 7401 Belair Rd | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|--|--|--------------------|---|---|--|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Kennett | MIDDLE W | LAST Hinks | 2a. DATE OF DEATH MONTH DAY YEAR July 22, 1982 | | 2b. HOUR 11:04p M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 09 03 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Advertising Exec. | | 12b. KIND OF BUSINESS OR INDUSTRY Advertising |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 13801 York Road |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Herbert Hinks | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Mary Webb | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI & WWII | | 17. INFORMANT Mrs. Diana Ziener, 5506 Center St., Chevy Chase | | | | |
| CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4271 IMMEDIATE CAUSE (a) Cardiac & respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) recurrent ventricular tachycardia DUE TO, OR AS A CONSEQUENCE OF (c) Concertina heart failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Concertina heart failure | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10⁵⁰ - 11⁰⁴ |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/16 , 19 82 , to 7/22 , 19 82 , that (I) (we) last saw the deceased alive on 7/22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Autograph CHI VAN DANG MD | | | | DEGREE CHI VAN DANG MD | | | 22c. DATE SIGNED 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHI VAN DANG | | | | 22e. ADDRESS 1620 McElderry | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 26, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul Epis. Church | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ivy, Virginia | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 23 1982 | | | | |

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 2. 17701 | |
| 1. DECEASED NAME (TYPE OR PRINT) Doris V. Hitt | | | |
| 3. SEX Female | | 4. RACE Cauc. | |
| 5. DATE OF BIRTH MONTH DAY YEAR 1/15/26 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 56 | |
| 7a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 7 6 1982 | | 7b. HOUR M 10:28 | |
| 7c. DATE PRONOUNCED DEAD 7 10 1982 | | 7d. HOUR a. M 10:28 | |
| 7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7f. CITIZEN OF WHAT COUNTRY? U.S. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1214 Cox Street | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker | | 12b. KIND OF BUSINESS OR INDUSTRY Blank&Decker | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Balto. | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 1214 Cox, St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ? ? ? | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 219-10-8640 | |
| 17. INFORMANT Husband | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I id | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | ADDRESS 111 Penn Street | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/14/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Meadowridge | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard Co. Md. | |
| 24. FUNERAL DIRECTOR Paul E. Chenoweth 3rd. | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | |
| ADDRESS 3617 Chestnut Ave. | | REGISTRAR'S SIGNATURE Paul E. Chenoweth 3rd. | |

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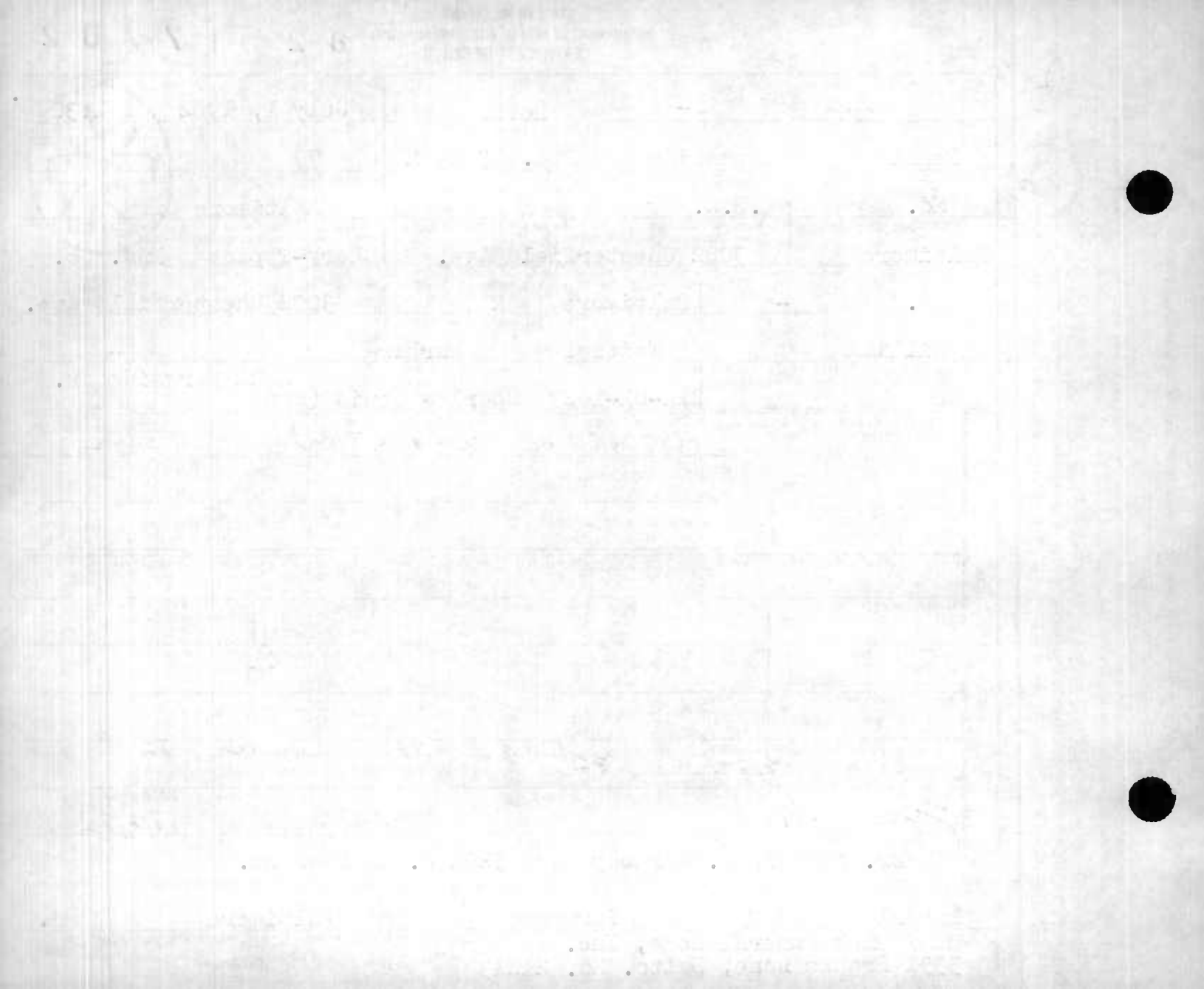
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 0 2 REG. NO. | |
|--|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Doretta - Hobbs | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 1, 1982 | | 2b. HOUR P. 1:30 M. | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 13 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 79 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3002 Chesterfield Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Typist | | 12b. KIND OF BUSINESS OR INDUSTRY Ins. Co. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY - | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3002 Chesterfield Ave. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Weitzel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara - | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO 212-01-1623 | | 17. INFORMANT Charles Louis (son) | | ADDRESS 4422 Parkside Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 MYOCARDIAL INFARCTION IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SAME | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 1976 to June 1982 , that (I) (we) last saw the deceased alive on 6/23/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dr. Francis X. Carmody | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/2/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Francis X. Carmody | | | | 22e. ADDRESS 3201 N. Charles St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/6/82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR Scrimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 2 1982 Francis J. Van Thullen | | | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other, requiring a medical examination, the medical examiner must be notified.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS E. HODGES | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1982 | | | 2b. HOUR 12⁴⁰ P.M. | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 7 7 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | 13b. COUNTY Harford | | 13c. CITY OR TOWN Aberdeen | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Richard Gray | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ophia Osey | | 13e. STREET ADDRESS 115 Darlington Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 220-22-0372 | | 17. INFORMANT ADDRESS Walter S. Hodges, 115 Darlington Ave., Aberdeen, Md. 21001 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) ADENOCARCINOMA, PRIMARY, UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/12/1982 to 7/18/1982 , that (I) (we) last saw the deceased alive on 7/18/1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CORNELIS HALMA, M.D. | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL 600 N. WOLFE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 21 July 82 | | 23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. 21205 | |
| 24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3899 | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 7 0 4 REG. NO. | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA F. HOFFMAN | | | | July 24, 1982 | | | | 2:45A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR April 7, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 59 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5482 Cedonia Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. COUNTY 21206 | | | | 13f. STREET ADDRESS 5482 Cedonia Avenue | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Milton Abbott | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Wilhelm | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-3182 | | 17. INFORMANT ADDRESS Frank W. Hoffman 5482 Cedonia Ave. 21206 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1701 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma of Mandible</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> 19 <u>82</u> , to <u>7/23</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/24</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23a. SIGNATURE <u>Jonathan P. Forman, MD.</u> | | | | DEGREE MD. | | | | 23b. DATE SIGNED <u>7/24/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan P. Forman, MD. | | | | 22e. ADDRESS 6466 Birchwood Ave Baltimore 21214 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 26, '82 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME William E. Johnson | | | | ADDRESS 8521 Loch Raven Blvd. | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 26 1982 <u>Frances Jan Nathan</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *Page may be retained by the hospital or attending physician.*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 7 | 0 | 5 |
|---|--|--|--|--|---|---|---|--|---|--|---|--|-----------------------------------|--|---|---|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Denton J. Hoffman | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 7, 1982 | | | | 2b. HOUR M | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 4 1914 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN. 0 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6907 Moyer Ave. | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6907 Moyer Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Adolph Hoffman | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irene Griffith | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Fanny G. Hoffman 6907 Moyer Ave. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/20 , 19 72 , to 4/7/82 , 19 82 , that (1) (we) last saw the deceased alive on 6/18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Alberto J. Diaz</i> | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 7/9/82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alberto J. Diaz, M.D. | | | | | 22e. ADDRESS 7600 Osler Drive Towson, Maryland | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE July 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | | | | |



100-1055-0-101

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 0 6

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Loretta Hoffmaster | | 2a. DATE OF DEATH MONTH DAY YEAR 7 23 82 | | 2b. HOUR 1:30 pm | |
| 3. SEX F Female | 4. RACE W. White | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier | | 12b. KIND OF BUSINESS OR INDUSTRY Market |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE Maryland | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 517 W. 28th Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Kreiner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Gordon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-14-0016 | | 17. INFORMANT ADDRESS Lester E. Hoffmaster 517 W. 28th Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Bone Marrow Depression 2nd Chemotherapy DUE TO, OR AS A CONSEQUENCE OF (c) Diffuse Histiocytic Lymphoma | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks 2 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 2000 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1/82 , 19 82 , to 7/23 , 19 82 , that (I) (we) lost saw the deceased alive on 7/22/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Kamel Dyal-Dottin DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. DYAL-DOTTIN | | | | 22e. ADDRESS 90 UMH | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 27, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 26 1982 [Signature] | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified to the



UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 2 1 7 7 0 7 | | | |
|--|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| Clarence HOLLAND | | | | July 23, 1982 | | | |
| 3. SEX Male | | 4. RACE Blk | | 5. DATE OF BIRTH 5 16 1942 | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE Md. | | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME Edward Holland | | | | 15. MOTHER'S MAIDEN NAME Susan Holland | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW I | | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT William Hudson | | | | ADDRESS 1657 Bakbury | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration, Hypothermia, Shock 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Sepsis and Lower Gastrointestinal hemorrhage (c) Urinary tract infection and pneumonitis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 48 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Dementia; Chronic Alcoholism; Hypertension; Cerebral vascular accident, OLD. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 22 19 82 to July 23 19 82, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 23 19 82, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph Nkwanyuo M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/23/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Nkwanyuo, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/26/82 | | MT. CALVARY | | BALTO Md. | |
| 24. FUNERAL DIRECTOR NAME JAS. A. MORTON & SONS | | | | ADDRESS 1701 LAURENS | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Theresa J. Weather | | | |

UNITED STATES
DEPARTMENT OF JUSTICE

July 23, 1952

WILLIAM

Lawrence

Mr. E. H.

U.S.A.

Division of Investigation

Mr.

U.S.A.

U.S.A.

Yes, Mr.

U.S.A.

Investigation, Division of

Severe and lower gastrointestinal hemorrhage, in large

Urinary tract infection and pyelitis

Acute chronic alcoholism, hypotension, cerebral vascular accident, etc.



July 23

July 23

Division of Investigation

Division of Investigation

U.S.A.

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

HHM-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | 8 2 1 7 7 0 8 | | | | | | |
|--|--|---|--|---|----------------|--|-------------------|---|----------------|-------------------|----------|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST MARY | | MIDDLE E | LAST HOLLOWMAN | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3 SEX F | | 4 RACE B | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | | |
| 14 FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT | | ADDRESS | | |
| 14a FIRST MIDDLE LAST | | 15a FIRST MIDDLE LAST | | 16a NO | | 16b 212-34-6888 | | 17 Arthur Hollowman | | 1948 Walbrook Ave | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| 1749 | | Metastatic breast cancer | | | | 2 years | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION | | | | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a I certify that (this hospital) attended the deceased from August 19 81 to 7/7/82 that (I) (we) lost saw the deceased alive on 7/7/82 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | |
| W. D. W. R. | | 22 S Greene St Balto 21201 | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | | | | | |
| Burial | | 7/12/82 | | Mt. Calvary Cem. | | CITY OR TOWN | | COUNTY | | STATE | | |
| | | | | | | Anne Arundel Co., Md. | | | | | | |
| 24 FUNERAL DIRECTOR | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | | |
| NAME | | ADDRESS | | | | | | | | | | |
| Wm. C. March F/H 1101 E. North Ave | | JUL 9 1982 | | Anne J. Hester | | | | | | | | |

MEDICAL CERTIFICATION

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DAVID

Belmont

Box 1 2/19/82

WILLIAM C. MARCH 6/11 1101 E. NORTH AVE JUL 8 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 7 0 9 | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY HOLLOWAY | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 24 82 | | 2b. HOUR 2:45 am | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 11 16 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? US | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2821 PRESSTMAN ST. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME JOSEPH MIDDLE HOLLOWAY | | | | 15. MOTHER'S MAIDEN NAME ADLINE MIDDLE UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT VIRGINIA WOODS | | ADDRESS 2821 PRESSTMAN ST. | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 4360 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> (c) <u>atherosclerotic Disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>February 6</u> , 19 <u>80</u> to <u>July 20</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED 7/27/82 | |
| 22b. SIGNATURE S. Johnson mo | | | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Johnson mo. | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-27-82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUS MEM. PK. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME E.L. PHILLIPS | | | | ADDRESS 1721 - 27 N. MONROE ST. | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | REGISTRAR SIGNATURE Renee [Signature] | | | |

[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]

1/1/95

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--|---|--|---|--|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ✓ JACOB C. HOLMES | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR ✓ 7 17 82 | | 2b. HOUR 338 A.M. | | | |
| 3. SEX M | | 4. RACE B. | | 5. DATE OF BIRTH MONTH DAY YEAR 03 12 09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO. MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTO. MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MO. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1527 BARCLAY ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ALBERT HOLMES. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE GORDON. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 215-16-5363 | | 17. INFORMANT ADDRESS Mildred Holmes 1527 Barclay Street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 1629 DUE TO, OR AS A CONSEQUENCE OF (b) NON-OAT CELL CARCINOMA LUNG. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) POST-OBSTRUCTIVE PNEUMONIA | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHRONIC RENAL FAILURE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/30 19 82 to 7/17 19 82 that (I) (we) last saw the deceased alive on 7/17 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Mary Carroll MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY CARROLL | | | | 22e. ADDRESS MERCY HOSPITAL - 301 ST. PAUL ST. BALTO. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY King Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co MD | | | | | |
| 24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | | | |

 REGISTRAR SIGNATURE
Frances Jan Nathan



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 1 1
REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|---|--|------------------|---|--|--------------------------------|---|---|--------------------------------|--|--------------------------------|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) WALTON B. HOLSEY, Sr | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 19 82 | | | 2b. HOUR 8:10 PM | | | | | | | | |
| 3. SEX M | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 02 26 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balti. Gen Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Trucking | | | | | |
| 13a. STATE MD | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1336 Washington Blvd. | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John H. Holsey | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Birmingham | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 215 05 0060 | | | 17. INFORMANT ADDRESS Frances H. Holsey Baltimo. MD. | | |

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|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> <u>5860</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cardiac Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal failure</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>07/19</u> , 19 <u>82</u> , to <u>07/19</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>07/19</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>D.L. Soler M.D.</u> | | | | DEGREE | | 22c. DATE SIGNED <u>07/19/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.L. Soler</u> | | | | 22e. ADDRESS <u>South Baltimore Gen Hospital</u> | | | |

| | | | | | | | |
|--|--|-------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 23 July 82 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, AA Md. | |
| 24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) JAMES BOURKE HOLTZNER | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 17 1982 | | 2b. HOUR 8:25 P.M. | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR NOV 19 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LINEMAN | | 12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN CATONSVILLE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 212-10-0370 | | 17. INFORMANT ADDRESS GEORGE E. HOLTZNER 712 KENT AVENUE, 21228 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from July 17, 1982, to July 17, 1982, that (1) (we) last saw the deceased alive on July 17, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Andrew F. Trofa DEGREE | | | | | | 22c. DATE SIGNED 17 July 1982 | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW F. TROFA | | | | | | 22f. ADDRESS 900 CATON AVE. BALTIMORE, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-21-82 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE ELKCRIDGE HOWARD MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR'S SIGNATURE Pascas Van Natten | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 8 2 1 7 7 1 3 | | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST | | | | | MONTH DAY YEAR HOUR | | | | |
| HENRY J. HOOK | | | | | 07 28 82 3:30A.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| MALE | | WHITE | | MONTH DAY YEAR 03 16 1891 | | 91 YRS. | | MONTHS DAYS HOURS MIN. | |
| 8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8b. CITIZEN OF WHAT COUNTRY? | | 8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | THE UNION MEMORIAL HOSPITAL | | | | DELIVERY MAN | | ARMSTRONG PUBLICATIONS | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | | |
| MARYLAND | | A.A. | | GLEN BURNIE | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | |
| UNKNOWN HOOK | | | | | ANNA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT | | | | | |
| YES | | WW I | | GLEN BURNIE, ADDRESS MARYLAND GEORGE HOOK 903 ROSEDALE AVE 21061 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) RIGHT CEREBROVASCULAR ACCIDENT | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a GANGRENE OF @ LEG | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/17, 19 82, to 7/28, 19 82, that (I) (we) last saw the deceased alive on 7/28, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Carl Sperling, M.D. | | | | DEGREE MD | | | | 22c. DATE SIGNED 7/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARL SPERLING, M.D. | | | | 22e. ADDRESS 201 E UNIVERSITY PARKWAY BALTO 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | 07-31-82 | | LOUDON PARK | | BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | | | 21229 | | JUL 30 1982 [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 2 1 7 7 1 4 | |
|---|--|--|--|--|----------------------|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | CERTIFICATE OF DEATH | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) AIFREDA | | | | | MIDDLE HORNE | | | | | LAST | |
| 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | | 2c. MIN. | |
| 7 | | 20 | | 82 | | 11 | | 34 | | AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| F | | B | | MONTH DAY YEAR 12 7 07 | | 74 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| ALABAMA | | U.S.A. | | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | |
| BALTO. | | LUTHERAN HOSP. | | | | | | | | | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| MD | | | | BALTO. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4609 MANORDENE RD. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST Ernest Franklin | | | | FIRST MIDDLE LAST Sallie Franklin | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | |
| No | | | | H19016209 | | | | Betty Mack 4609 Manordena Rd. 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Cardio-pulmonary arrest | | | | | | | | | | | |
| 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of colon & metastatic | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| S. Sumanapone | | | | Lutheran Hospital, Baltimore MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 7/24/82 | | Indian Ridge | | Whatley Alabama | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Chas A. Rice FSPA 1300 Tutaw PL. | | | | | | AUG - 2 1982 | | James Van Natten | | | |

9

UNITED STATES

POST OFFICE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 7 7 1 5
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|------------------------------------|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) ALBERT | | FIRST HORNZELL | | LAST | | 2a. DATE OF DEATH MONTH 07-30-82 | | DAY | | YEAR | | 2b. HOUR 4A | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH 04-10-1995 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | YRS | | IF UNDER 1 YEAR MONTHS 84 | | IF UNDER 24 HRS DAYS 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN WORKING LIFE) MACHINIST | | 12b. KIND OF BUSINESS OR INDUSTRY METAL | | | | | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN BALTO. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 8517 8715 GLEN MICHAEL LA. 21133 | | | | | | | |
| 14. FATHER'S NAME FIRST ISADORE | | MIDDLE ORNZELL | | LAST WESLER | | 15. MOTHER'S MAIDEN NAME FIRST PAULINE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-12-4055 | | 17. INFORMANT MRS. HARRIET HORNZELL | | 18. DATE OF OPERATION 06-10-82 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 | | IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT | | DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE, ESOPHAGEAL OBSTRUCTION | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed. | | | | | | | |
| 19a. DATE OF OPERATION 06-10-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RENAL FAILURE, ESOPHAGEAL OBSTRUCTION | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 06-10-82 to 07-30-82 , that (I) (we) lost saw the deceased alive on 07-30-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE B. ZAW-LIN | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/30/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-LIN | | 22e. ADDRESS Levinvale Geriatric Ctr 21215 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | |
| 23b. DATE JULY 30, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH | | 23d. LOCATION CITY OR TOWN BALTIMORE COUNTY MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D BY REGISTRY AUG-3-1982 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE James J. Patton | | 25c. REGISTRAR'S NAME James J. Patton | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL
EXCLUDED FROM AUTOMATIC DOWNGRADING AND DECLASSIFICATION
DATE 01/11/2011 BY 60322 UCBAW

SECRET - DUA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 7 1 6 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | |
| FIRST MIDDLE LAST WATINA HORTON | | | | MONTH DAY YEAR HOUR JULY 7 22 82 10 ⁵⁵ M | | | |
| 3. SEX | | 4. RACE | | 5. OCTOBER 10 31 1929 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) | |
| Female | | NEGRO | | 10 31 1929 | | 52 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NORTH CAROLINA | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | | Good Samaritan Hospital | | L.P.N. | | HOSPITAL | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| MARYLAND | | | | BALTIMORE | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST ARTHUR VICK | | FIRST MIDDLE LAST ROBERTA JONES | | 1245 SHERIDAN AVE. 21239 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | 219-30-9436 | | MACK B. HORTON | | 1245 SHERIDAN AVENUE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> | | | | | | | |
| 3489 DUE TO, OR AS A CONSEQUENCE OF (b) <u>UNKNOWN CAUSE RELATED TO BRAIN DAMAGE</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>7/17/82</u> | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| | | P.M. 15 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUL 17</u> , 19 <u>82</u> , to <u>JUL 22</u> , 19 <u>82</u> , that (I) (we) last saw the decedent alive on <u>JUL 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>P. Kennedy</u> | | MD | | | | 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| P. KENNEDY, MD. | | GSH | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| BURIAL | | 07/26/82 | | ARBUTUS MEM PARK | | BALTIMORE BALTO. Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MARSHALL W JONES, JR/4101 EDMONDSON AVE | | JUL 26 1982 | | Frances Jean Nathan | | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

1 7 7 1 7

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roscoe Howard Jr. | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-5-82 | | 2b. HOUR 2:00 A.M. | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8-29-36 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MD | | | | 13b. COUNTY City | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roscoe Howard Sr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Judy Ann Powell | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 242-54-7495 | | | | 17. INFORMANT ADDRESS 214 Ridgewood Rd. Baltimore, N.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0384 IMMEDIATE CAUSE (a) Septic shock DUE TO, OR AS A CONSEQUENCE OF (b) gross septic shock sepsis DUE TO, OR AS A CONSEQUENCE OF (c) ARDS and DIC (adult respiratory distress syndrome + disseminated intravascular coagulation) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARDS and DIC (adult respiratory distress syndrome + disseminated intravascular coagulation) | | | | | | | | | |
| 19a. DATE OF OPERATION 7/14 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ARDS and DIC | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) --- | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 82 , to 7/15 , 19 82 , that (I) (we) last saw the deceased alive on 2:00 AM 7/15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. Zweier MD | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Zweier MD | | | 22e. ADDRESS Sinai Hospital Baltimore | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/11/82 | | 23c. NAME OF CEMETERY OR CREMATORY Community Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Tarboro N.C. | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | ADDRESS 1101 E. North Ave. | | | 25a. DATE REC'D. BY REGISTRAR JUL 6 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Martin | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81
(VRA 15, 4)FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 1 7 7 1 8

| | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FLORENCE B. HOWE | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 12 82 | | | 2b. HOUR 4.02 pm | | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 4 13 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 0 | | 8. IF UNDER 24 HRS HOURS MIN. 0 0 | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY Ft. Holabird | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2045 Larkhall Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick Birkmaier | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Houston | | | | 16. ADDRESS 2045 Larkhall Rd. Balto., MD. 21222 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 213-14-3836 | | 17. INFORMANT Edward J. Howe, Sr. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) severe coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 82 , to July , 19 82 , that (I) (we) lost saw the deceased alive on June 11th , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Nishi Chandra | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/12/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) NISHI CHANDRA, MD. | | | | 22e. ADDRESS BALT. CITY HOSP. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/15/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Holly Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Duda Ruck Gerard Louden | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | | |

MEDICAL CERTIFICATION



NOTICE

Wm. H. H. H.

Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 7 | 1 | 9 | | |
|--|--|--|---|--|---|--|--|--|--|--|---|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOSEPH HUDLICKA SR. | | | | | | | | | | 2a. DATE OF DEATH MONTH 7 DAY 20 YEAR 82 2b. HOUR 12 55A | | | | | | | | |
| 3. SEX MALE | | | 4. RACE CAUCASIAN | | | 5. DATE OF BIRTH MONTH 01 DAY 03 YEAR 1893 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | | IF UNDER 1 YEAR MONTHS 00 DAYS 00 | | IF UNDER 24 HRS. HOURS 00 MIN. 00 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BOHEMIA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) DRIVER | | | 12b. KIND OF BUSINESS OR INDUSTRY MTA | | | | | |
| 13a. STATE MARYLAND | | | | | | | | | | 13b. COUNTY ---- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 715 N. MADEIRA ST. | | |
| 14. FATHER'S NAME FIRST WENCESLAUS MIDDLE HUDLICKA LAST REHA | | | | | 15. MOTHER'S MAIDEN NAME FIRST MARIE MIDDLE REHA LAST REHA | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. 213101215 | | | | | 17. INFORMANT ADDRESS LEONARD HUDLICKA 4802 GREENCREST RD. | | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| DUO TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION | | | | | | | | | | 2 - days | | | | | | | | |
| DUO TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M. | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (1) this hospital attended the deceased from JULY 18 , 19 82 , to JULY 20 , 19 82 , that (1) (we) last saw the deceased alive on JULY 20 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Robert J. Varipapa DEGREE MD | | | | | | | | | | 22c. DATE SIGNED 7/20/82 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. VARIPAPA, M.D. | | | | | | |
| 22e. ADDRESS 201 E. UNIVERSITY PARKWAY | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | 23b. DATE 7/23/82 | | | | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | | | | | | | |
| 23d. LOCATION CITY OR TOWN BALTO. COUNTY MD. STATE MD. | | | | | 23e. DATE REC'D. BY REGISTRAR JUL 21 1982 | | | | | 23f. REGISTRAR'S SIGNATURE Francis Santhorne | | | | | | | | |
| 24. FUNERAL DIRECTOR Jhfcoal ADDRESS 1211 Chesaco Ave. | | | | | | | | | | | | | | | | | | |

22-23/02/5

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MAITLAND

APPENDIX

REVIEWER

• 02 APRIL • 1

FRONTIER

1990s, 2000s, 2010s, 2020s

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12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

[illegible]

U. S. 7374

5-11-11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information other than death information. Page 3 should be filled with information other than death information. Page 4 should be filled with information other than death information.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 7 2 0 | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jen Kins Hudson Jr. | | | | 2a. DATE OF DEATH MONTH 7 DAY 21 YEAR 82 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MO 11 DAY 4 YEAR 34 | | 6. AGE (IN YEARS LAST BIRTHDAY) 47 | |
| 7a. BIRTHPLACE COUNTRY S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balti. City | |
| 10. CITY OR TOWN OF DEATH Balti. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Deaton Med. Ctr. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY Balti. | | 13c. CITY OR TOWN Balti. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST Jen Kins MIDDLE Hudson Sr. LAST Dora | | 15. MOTHER'S MAIDEN NAME FIRST Dora MIDDLE Fleming LAST Fleming | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) | | | |
| 16a. SOCIAL SECURITY NO. 242-48-1210 | | 17. INFORMANT ADDRESS Sylvester Hudson 216 N. Fulton | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic encephalopathy 5713 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) alcoholic liver disease DUE TO, OR AS A CONSEQUENCE OF (c) years | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22 , 19 82 to 7/21 , 19 82 , that (I) (we) lost saw the deceased alive on 7/21 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Dora E. King | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DE KING | | | | 22e. ADDRESS J.L. Deaton | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | 23d. LOCATION CITY OR TOWN Balti. COUNTY MD STATE | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 25b. REGISTRAR'S SIGNATURE Frances VanNathan | | | |

103018

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

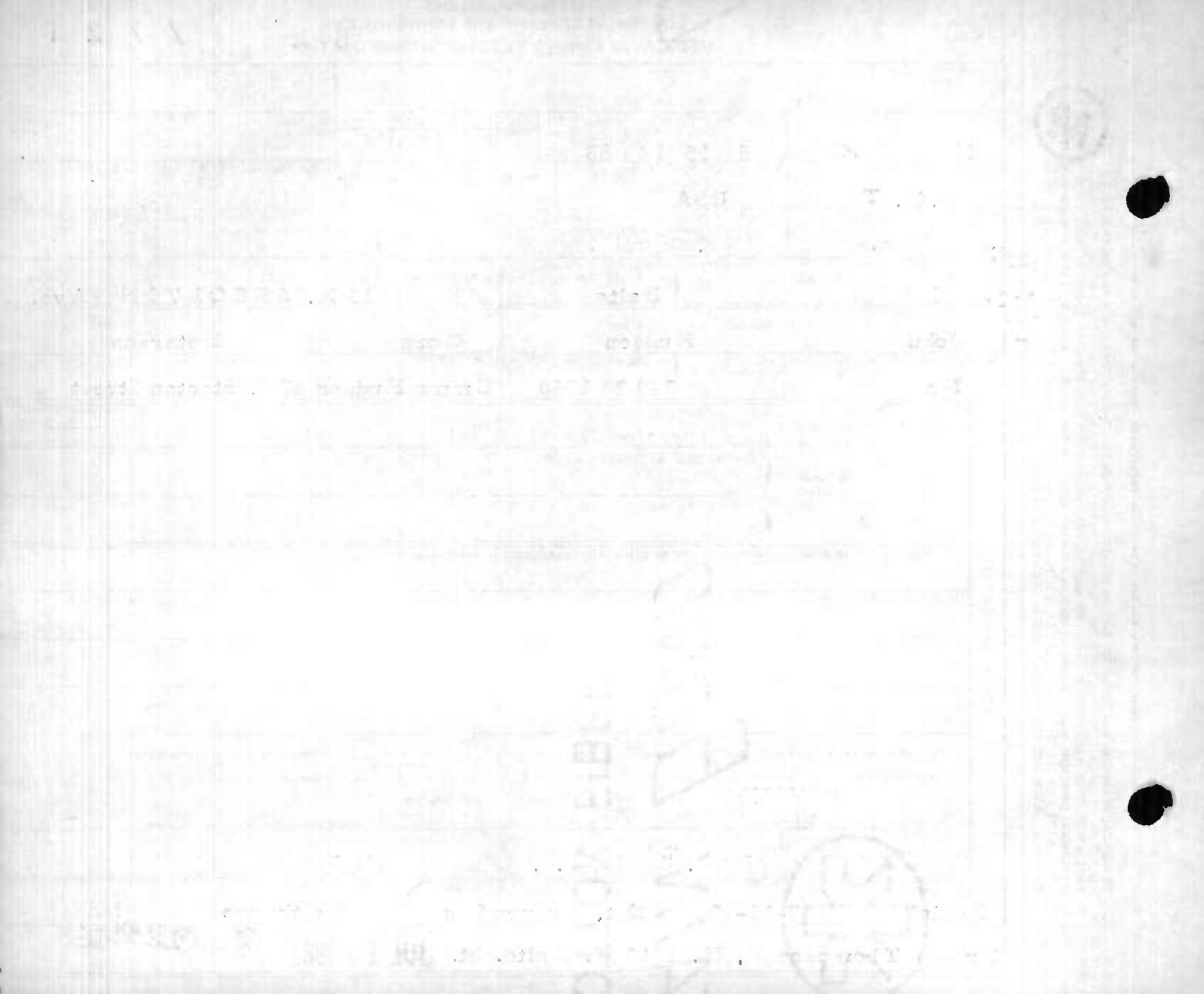
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17721

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. DATE KNOWN OF DEATH | | 2c. DATE KNOWN OF DEATH | | 2d. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | |
| John Hudson | | M | | B | | 5 15 14 | | 68 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| S.C. | | USA | | X NEVER MARRIED | | Baltimore City | | Baltimore | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS | | 13b. CITY OR TOWN | |
| 15 S. Carrollton Avenue | | | | | | 15 N. CARROLLTON Ave. | | Balto | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| John Hudson | | Cora Peterson | | No | | 249 24 1850 | | Emma Hudson 47 S. Stocton Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | 21a. EXTERNAL CAUSE WAS | |
| PART I DEATH WAS CAUSED BY: | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease | | | | | | | | 21b. TIME OF INJURY | |
| 4292 | | | | | | | | HOUR A.M. MONTH DAY YEAR | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | P.M. 19 | |
| (b) | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | 21d. INJURY OCCURRED | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| (b) | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | 21f. LOCATION | |
| (c) | | | | | | | | STREET CITY OR TOWN COUNTY STATE | |
| PART 2 OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | |
| | | | | | | | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | |
| Margarita A. Korell, M.D. | | Assistant | | 7-10-82 | | Burial | | 7-15-82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | 23e. DATE REC'D. BY REGISTRAR | |
| | | 111 Penn Street | | NMt. Auburn Cem | | Baltimore Md | | JUL 13 1982 | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. DATE REC'D. BY REGISTRAR | | 25c. DATE REC'D. BY REGISTRAR | | 25d. DATE REC'D. BY REGISTRAR | |
| Brown/Thompson F. H. 1913 W. Balto. St. | | JUL 13 1982 | | JUL 13 1982 | | JUL 13 1982 | | JUL 13 1982 | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17722

| | | | | | | | | | | | | | |
|--|---------|--|--|--|--|--------------------------------------|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR | | 2b. HOUR | |
| Louis C. Hummer Jr. | | | | | | | | 7 619 82 | | | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| M | Cau. | 4 24 12 | | 70 89 | | | | | | 7 619 82 | | 7:50 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Md. | | U.S.A. | | | | Baltimore City | | | | | | MD | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Balto. | | Johns Hopkins Hosp. | | Salesman | | Sears-Robuck | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md. | | | | - | | Balto. | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3115 Belair Rd. 21213 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Louis C. Hummer Sr. | | Alice Doud | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| no | | 215-01-2796 | | Myrtle M. Hummer | | 3115 Belair Rd. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7/7/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | III Penn St. Balto., MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | 7-10-82 | | | | Holy Redeemer Cem. | | | | | |
| | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| John C. Miller Inc. 6415 Belair Rd. | | | | JUL 7 1982 | | | | [Signature] | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 2 3 REG. NO. | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|--|--|---------------------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry E. Hundt | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 22, 1982 | | 2b. HOUR MIN. 10:20P. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 810 N. Rose Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Baker | | 12b. KIND OF BUSINESS OR INDUSTRY Bakery | | | | | | | | | |
| 13a. STATE Md. | | | | | | | | | | 13b. COUNTY ---- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 810 N. Rose Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hundt | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Cuesh | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-03-2827 | | 17. INFORMANT Baltimore, Md. 21205. Mrs. Marie C. Hundt-810 N. Rose St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) COPD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION _____ | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) _____ | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____ | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____ | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 79 , to 7-19 , 19 82 , that (I) (we) last saw the deceased alive on July 17th , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-23-82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose H. Ordonez-Smith MD | | | | 22e. ADDRESS 2601 E. Monument St 21205 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME John A. Moran, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | | | | 25b. REGISTRAR'S SIGNATURE James Van Kester | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

| FOR Items 18b Film 572 10-19-82 | | | | | | | | | |
|--|--|---|--|--|---|--|------------------------|---|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 82 17724 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Charlotte L. Hunker | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 22 82 | | 2b. HOUR 555 PM | | |
| 3. SEX ♀ | | 4. RACE Wht | | 5. DATE OF BIRTH MONTH DAY YEAR 9 4 19 62 | | 6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) house-wife | | 12b. KIND OF BUSINESS OR INDUSTRY home | |
| 13a. STATE Maryland | | 13b. COUNTY <input checked="" type="checkbox"/> | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1211 Steelton Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jol Ness | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST I da Wolf | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 220 07 8058 | | 17. INFORMANT ADDRESS Charles Hunker 1211 Steelton Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Anterolateral K. Iliot M Non Insulin Dependent Diabetes Mellitus & Hypertension DUE TO, OR AS A CONSEQUENCE OF NIDDM, Htn, Periph Vasc Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/22 82 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/22 82 to 7/22 82 that (I) (we) lost 7/22 82 above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Hal Cook MD | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/22/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hal Cook MD | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn | | 23d. LOCATION CITY OR TOWN Baltimore COUNTY STATE Md | | | |
| 24. FUNERAL DIRECTOR NAME Walter Dabrowski ADDRESS 1005 Dundalk Avenue | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 25b. REGISTRAR'S SIGNATURE Jones Jan Nathan | | | |

| | | | | | | |
|-----|-------------|----------------|----------------------|-----------|-----|-----|
| 101 | mess | I am | 1211 Steelton Avenue | Baltimore | USA | 101 |
| no | 220 07 8028 | Charles Hunter | 1211 Steelton Avenue | Baltimore | USA | 101 |
| 101 | mess | I am | 1211 Steelton Avenue | Baltimore | USA | 101 |
| 101 | mess | I am | 1211 Steelton Avenue | Baltimore | USA | 101 |

Burial 7/20/82 Oak Lawn Baltimore

Walter Oskowski 1005 Dundalk Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and the body autopsied.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 2 5 | | | | | |
|---|--|---|--|---|--|---|--|--|--|-----------------------------------|--|--|--|----------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| LEE B. HUNT JR. | | | | | | JULY | | 4 | | 1982 | | 12:15 | | A | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS. | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Male | | White | | 12 26 1932 | | 49 YRS | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Alabama | | U.S.A. | | | | Baltimore City | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | Church Hospital Corporation | | | | Electrician | | | | Beth. Steel | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| Maryland | | Baltimore | | Dundalk | | | | 8063 Stratman Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| Lee B. Hunt, Sr. | | | | Essie Lora Grantham | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | 8063 Stratman Rd. | | | | | | | |
| Yes | | Korea | | 219-28-7929 | | | | Donna J. Watts | | | | Balto., MD. 21222 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER, METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADENOCARINOMA STOMACH</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 28,</u> 19 <u>82</u> , to <u>July 4,</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>July 4,</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Steve Nelson, M.D. | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STEVE NELSON M.D. | | | | | | 22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTO. MD. 21231 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Entombment | | 7/7/1982 | | Holly Hill | | White Marsh Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222 | | | | | | 25a. DATE JUL 6 1982 | | 25b. BY REGISTRAR (b) REGISTRAR'S SIGNATURE | | | | | | | |

2211750



17-10-1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8217726 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT HUNT | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/19/82 | | 2b. HOUR 12:49 PM | |
| 3. SEX MALE | | 4. RACE NEGROID | | 5. DATE OF BIRTH MONTH DAY YEAR 7 28 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 67 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Hunt | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary | | 13e. STREET ADDRESS 21216 3104 BELLMONT AVE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 227-14-0492 | | 17. INFORMANT ADDRESS Christine Hunt 3104 Belmont Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151 Acute massive pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION 7/19/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary embolism | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/19 , 19 82 , to 7/19 , 19 82 , that (I) (we) last saw the deceased alive on 7/19/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Karl F. Meck, Jr. PA. | | DEGREE MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL F. MECK, JR. | | 22e. ADDRESS 3350 WILKENS AVE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Louisa Ph. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | ADDRESS 1101 E. North | | 25a. DATE RECEIVED BY REGISTRAR'S SIGNATURE JUL 21 1982 Frances Jan Thirren | |

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2007-2008-2009-2010-2011-2012-2013-2014-2015-2016-2017-2018-2019-2020-2021-2022-2023-2024-2025-2026-2027-2028-2029-2030-2031-2032-2033-2034-2035-2036-2037-2038-2039-2040-2041-2042-2043-2044-2045-2046-2047-2048-2049-2050-2051-2052-2053-2054-2055-2056-2057-2058-2059-2060-2061-2062-2063-2064-2065-2066-2067-2068-2069-2070-2071-2072-2073-2074-2075-2076-2077-2078-2079-2080-2081-2082-2083-2084-2085-2086-2087-2088-2089-2090-2091-2092-2093-2094-2095-2096-2097-2098-2099-2100-2101-2102-2103-2104-2105-2106-2107-2108-2109-2110-2111-2112-2113-2114-2115-2116-2117-2118-2119-2120-2121-2122-2123-2124-2125-2126-2127-2128-2129-2130-2131-2132-2133-2134-2135-2136-2137-2138-2139-2140-2141-2142-2143-2144-2145-2146-2147-2148-2149-2150-2151-2152-2153-2154-2155-2156-2157-2158-2159-2160-2161-2162-2163-2164-2165-2166-2167-2168-2169-2170-2171-2172-2173-2174-2175-2176-2177-2178-2179-2180-2181-2182-2183-2184-2185-2186-2187-2188-2189-2190-2191-2192-2193-2194-2195-2196-2197-2198-2199-2200-2201-2202-2203-2204-2205-2206-2207-2208-2209-2210-2211-2212-2213-2214-2215-2216-2217-2218-2219-2220-2221-2222-2223-2224-2225-2226-2227-2228-2229-2230-2231-2232-2233-2234-2235-2236-2237-2238-2239-2240-2241-2242-2243-2244-2245-2246-2247-2248-2249-2250-2251-2252-2253-2254-2255-2256-2257-2258-2259-2260-2261-2262-2263-2264-2265-2266-2267-2268-2269-2270-2271-2272-2273-2274-2275-2276-2277-2278-2279-2280-2281-2282-2283-2284-2285-2286-2287-2288-2289-2290-2291-2292-2293-2294-2295-2296-2297-2298-2299-2300-2301-2302-2303-2304-2305-2306-2307-2308-2309-2310-2311-2312-2313-2314-2315-2316-2317-2318-2319-2320-2321-2322-2323-2324-2325-2326-2327-2328-2329-2330-2331-2332-2333-2334-2335-2336-2337-2338-2339-2340-2341-2342-2343-2344-2345-2346-2347-2348-2349-2350-2351-2352-2353-2354-2355-2356-2357-2358-2359-2360-2361-2362-2363-2364-2365-2366-2367-2368-2369-2370-2371-2372-2373-2374-2375-2376-2377-2378-2379-2380-2381-2382-2383-2384-2385-2386-2387-2388-2389-2390-2391-2392-2393-2394-2395-2396-2397-2398-2399-2400-2401-2402-2403-2404-2405-2406-2407-2408-2409-2410-2411-2412-2413-2414-2415-2416-2417-2418-2419-2420-2421-2422-2423-2424-2425-2426-2427-2428-2429-2430-2431-2432-2433-2434-2435-2436-2437-2438-2439-2440-2441-2442-2443-2444-2445-2446-2447-2448-2449-2450-2451-2452-2453-2454-2455-2456-2457-2458-2459-2460-2461-2462-2463-2464-2465-2466-2467-2468-2469-2470-2471-2472-2473-2474-2475-2476-2477-2478-2479-2480-2481-2482-2483-2484-2485-2486-2487-2488-2489-2490-2491-2492-2493-2494-2495-2496-2497-2498-2499-2500-2501-2502-2503-2504-2505-2506-2507-2508-2509-2510-2511-2512-2513-2514-2515-2516-2517-2518-2519-2520-2521-2522-2523-2524-2525-2526-2527-2528-2529-2530-2531-2532-2533-2534-2535-2536-2537-2538-2539-2540-2541-2542-2543-2544-2545-2546-2547-2548-2549-2550-2551-2552-2553-2554-2555-2556-2557-2558-2559-2560-2561-2562-2563-2564-2565-2566-2567-2568-2569-2570-2571-2572-2573-2574-2575-2576-2577-2578-2579-2580-2581-2582-2583-2584-2585-2586-2587-2588-2589-2590-2591-2592-2593-2594-2595-2596-2597-2598-2599-2600-2601-2602-2603-2604-2605-2606-2607-2608-2609-2610-2611-2612-2613-2614-2615-2616-2617-2618-2619-2620-2621-2622-2623-2624-2625-2626-2627-2628-2629-2630-2631-2632-2633-2634-2635-2636-2637-2638-2639-2640-2641-2642-2643-2644-2645-2646-2647-2648-2649-2650-2651-2652-2653-2654-2655-2656-2657-2658-2659-2660-2661-2662-2663-2664-2665-2666-2667-2668-2669-2670-2671-2672-2673-2674-2675-2676-2677-2678-2679-2680-2681-2682-2683-2684-2685-2686-2687-2688-2689-2690-2691-2692-2693-2694-2695-2696-2697-2698-2699-2700-2701-2702-2703-2704-2705-2706-2707-2708-2709-2710-2711-2712-2713-2714-2715-2716-2717-2718-2719-2720-2721-2722-2723-2724-2725-2726-2727-2728-2729-2730-2731-2732-2733-2734-2735-2736-2737-2738-2739-2740-2741-2742-2743-2744-2745-2746-2747-2748-2749-2750-2751-2752-2753-2754-2755-2756-2757-2758-2759-2760-2761-2762-2763-2764-2765-2766-2767-2768-2769-2770-2771-2772-2773-2774-2775-2776-2777-2778-2779-2780-2781-2782-2783-2784-2785-2786-2787-2788-2789-2790-2791-2792-2793-2794-2795-2796-2797-2798-2799-2800-2801-2802-2803-2804-2805-2806-2807-2808-2809-2810-2811-2812-2813-2814-2815-2816-2817-2818-2819-2820-2821-2822-2823-2824-2825

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 2 7 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isaac N. Huntsberry | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07/18/82 | | 2b. HOUR 4:10PM | | | |
| 3 SEX Male | | 4 RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 28 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY) 79 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7c. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver | | 12b. KIND OF BUSINESS OR INDUSTRY School | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY Ohio Monroe Clarington | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> xx | | 13e. STREET ADDRESS Rt. 1 Box 264 Clarington, Ohio | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert A. Huntsberry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melinda Posey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 235-22-9305 | | 17. INFORMANT ADDRESS Leah M. Huntsberry Rt. 1 Box 264 Ohio | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of pancreas. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 10 hours. 4 weeks from diagnosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: | | | | | | | | | |
| 19a. DATE OF OPERATION 6/22/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of pancreas | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> x | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> x | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7/1 , 19 82 , to 7/18 , 19 82 , that (I) (we) last saw the deceased alive on 7/18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Timothy G. Buchanan | | | | DEGREE MD | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> x | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Timothy G. Buchanan | | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 22, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Clarington Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Clarington Ohio | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JUL 19 1982 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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Edward J. Cook, Inc. 101 Moore, Maryland

July 11, 1966 Christian County

Clinton

Part 1



[Faint, illegible handwritten text and markings, possibly a signature or address, covering the lower half of the page.]

No

877-22-077 Leah H. Hamblen, Rt. 1 Box 20

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Hamblen, Leah H.

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Rt. 1 Box 20, Clinton, Mo.

S. L. one

Leah H. Hamblen, Rt. 1 Box 20

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Items 13a-e per phone 8/4/82 dad STATE OF MARYLAND

| | | | | | |
|---|---|---|---|---|--|
| 1- STATE REGISTRAR Jacob Andrew | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 7 7 2 8 REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HURLINE | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 29, 1982 | | 2b. HOUR 10:10p |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR July 28, 1982 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 1 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH baltimore city MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none | |
| 13a. STATE Md. | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Baldwin | 13d. STREET ADDRESS 14218 Greene Rd. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Philip J. Hurline | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carol Bittner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS Baldwin, Md. Philip J. Hurline 14218 Greene Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 7468 DUE TO, OR AS A CONSEQUENCE OF (b) hypoplastic left heart DUE TO, OR AS A CONSEQUENCE OF (c) birth Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-29 , 19 82 , to 7-29 , 19 82 , that (I) (we) last saw the deceased alive on 7-29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Daniel Jackson MD | | DEGREE MD | | 22c. DATE SIGNED 7/29/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Jackson | | 22e. ADDRESS Johns Hopkins Hospital - NICU | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/1982 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Luthern | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Phoenix, Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME M. Gladden Kurtz | | | 25a. DATE REC'D. BY REGISTRAR AUG 2 1982 | | |
| 25b. REGISTRAR'S SIGNATURE James Van Winkle | | | | | |



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17729 | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2. DECEASED NAME (TYPE OR PRINT) Gertrude Huston | | | | | | | | | |
| 3. SEX FEMALE | | | | | 4. RACE WHITE | | | | | 5. DATE OF BIRTH 4 5 06 | | | | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. AGE (IN YEARS LAST BIRTHDAY) 76 | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired EMPLOYEE | | | | | 12b. KIND OF BUSINESS OR INDUSTRY CITY OF BALTIMORE | | | | | 13a. STREET ADDRESS 4101 Bayward Ave | | | | |
| 14. FATHER'S NAME ZEVLON | | | | | 15. MOTHER'S MAIDEN NAME RACHEL KARTUNE | | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | |
| 17. INFORMANT MRS. MARILYN RUDO | | | | | 18. SOCIAL SECURITY NO. 212-22-6551 | | | | | 19. ROUTE 3 BOX 500-55 | | | | |
| 20. ADDRESS OLIVERSPRINGS, TN. 37840 | | | | | 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PROBABLE MI DUE TO, OR AS A CONSEQUENCE OF (c) 4 hrs | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a R.I.D. | | | | | | | | | | 19a. DATE OF OPERATION | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Georgia L. Gilmore DEGREE MD | | | | | | | | | | 22c. DATE SIGNED 7.11.82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGIA L. GILMORE | | | | | | | | | | 22e. ADDRESS SINAI HOSPITAL | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | | | | | 23b. DATE JULY 13, 1982 | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L CEM | | | | | | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | | | |
| 25b. REGISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | | | 25c. REGISTRAR'S SIGNATURE James J. Kathan | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 3 0 | |
|---|--|--|---|---|--|---|--|--|--|---------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY J. HYMAN Sr. | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 1 82 | | 2b. HOUR 10.45AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 27, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3512 Old York Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William H. Hyman | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna M. Brown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | 16b. SOCIAL SECURITY NO. 212-07-2644 | | 17. INFORMANT ADDRESS Mrs. Bernice Hyman same | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Pulmonary failure. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Severe Congestive heart failure - several yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary infarction. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4151 - 6 weeks. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Peripheral embolus to right & third toe, Diabetic Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION - | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) - | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) - | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE - | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 6/14/1982 , to 7/1/1982 , that (he) saw the deceased alive on 7/1/1982 , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A. Sirithara | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/1/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. SIRITHARA. | | | | | | 22e. ADDRESS 201 E. UNIVERSITY PARKWAY | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE July 6, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY New CAthedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 2 1982 Charles J. Nathan | | | | | |

RECEIVED
JAN 10 1965

UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

OFFICE OF THE SECRETARY

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UNITED STATES

DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY



UNITED STATES

DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 7 3 1 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy Larue Ingels | | | | 2b. HOUR 5:35 AM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 21 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD. | |
| 10. CITY OR TOWN OF DEATH Balto | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Md | | 13b. CITY OR TOWN Catonsville | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS 40 Mellor Avenue 21228 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ralph C. Hood | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tolia Ada C. Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 212-03-9121 | | 17. INFORMANT ADDRESS Leonard W. Ingels Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD + Cardiac Arrhythmias. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Chronic Renal Failure. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-25, 19 82 , to 7-26, 19 82 , that (I) (we) lost 2/26, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richardson DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. MACNAB DO. MD. | | | | 22e. ADDRESS St Agnes Hospital Balto, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Torraine Pk. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md. | |
| 24. FUNERAL DIRECTOR NAME MacNabb Funeral Home Catonsville, Md. ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 25b. REGISTRAR'S SIGNATURE Frances Jan Thorne | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 7 3 2

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--------------------------------------|--|--------------------------------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | XX MONTH DAY YEAR | | 2b. HOUR | |
| ARTHOR | | JACKSON | | | | | | 7-3-82 | | 19 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| M | Blk | 11-25-24 | | 57 YRS. | | | | | | 7-3-82 | | 1:03A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md | | U.S.A | | WIDOWED | | DIVORCED | | Baltimore City | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Baltimore | | 2121 Windsor Garden Lane | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | |
| Md | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2121 Windsor Garden Ln | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| ARTHUR | | JACKSON | | BENTLEY | | GAITHER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | | | Belle Chandler | | 2416 Loyola Northway | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | TITLE (SPECIFY) M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED 7-3-82 | | | | | | | |
| ACTUAL SIGNATURE Virginia L. Dolan | | EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/8/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Vernon R. Bailey | | 1348 N. Calhoun St | | JUL 6 1982 | | Frances Jan. Northern | | | | | | | |

BP

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]



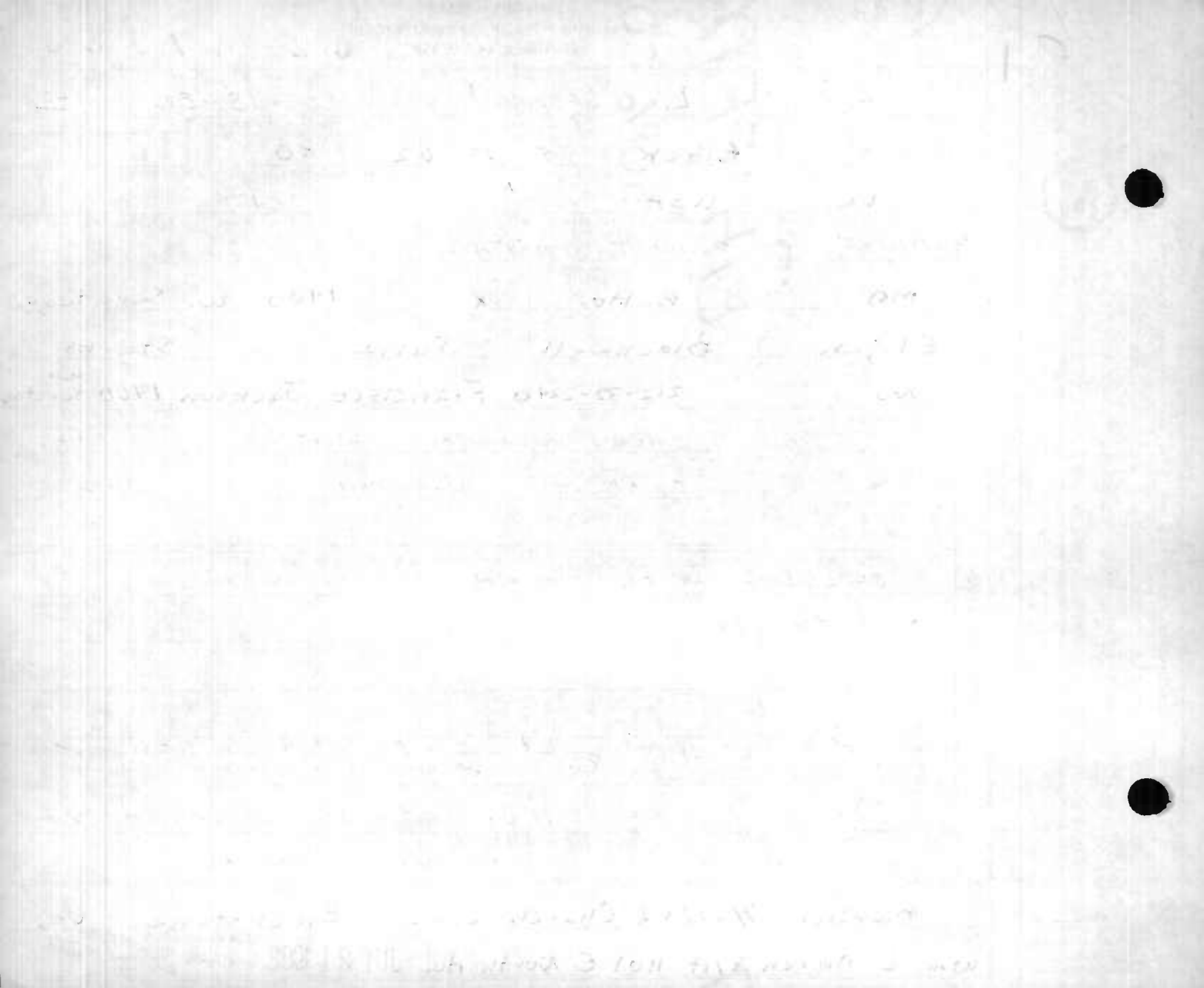
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 REG. NO. 1 7 7 3 3 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) GRACIE L. JACKSON | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-18-'82 | | | |
| 3. SEX FEMALE | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 5 23 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PROVIDENT HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1400 W. Saratoga | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Elijah Blackwell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Starks | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-32-2240 | | 17. INFORMANT ADDRESS W. Francisco Jackson 1400 Saratoga | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 1519 DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 MINUTES - DAYS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CARCINOMA OF THE STOMACH | | | | | | | |
| 19a. DATE OF OPERATION 07/09/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. OF THE STOMACH | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7/18 1982 , to 7/18 1982 , that (1) (we) lost saw the deceased alive on 7/18 1982 , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Donald R. Ware | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. WARE | | | | 22e. ADDRESS PROVIDENT HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Blackstone Va. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave | | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Frances Jean Patten | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

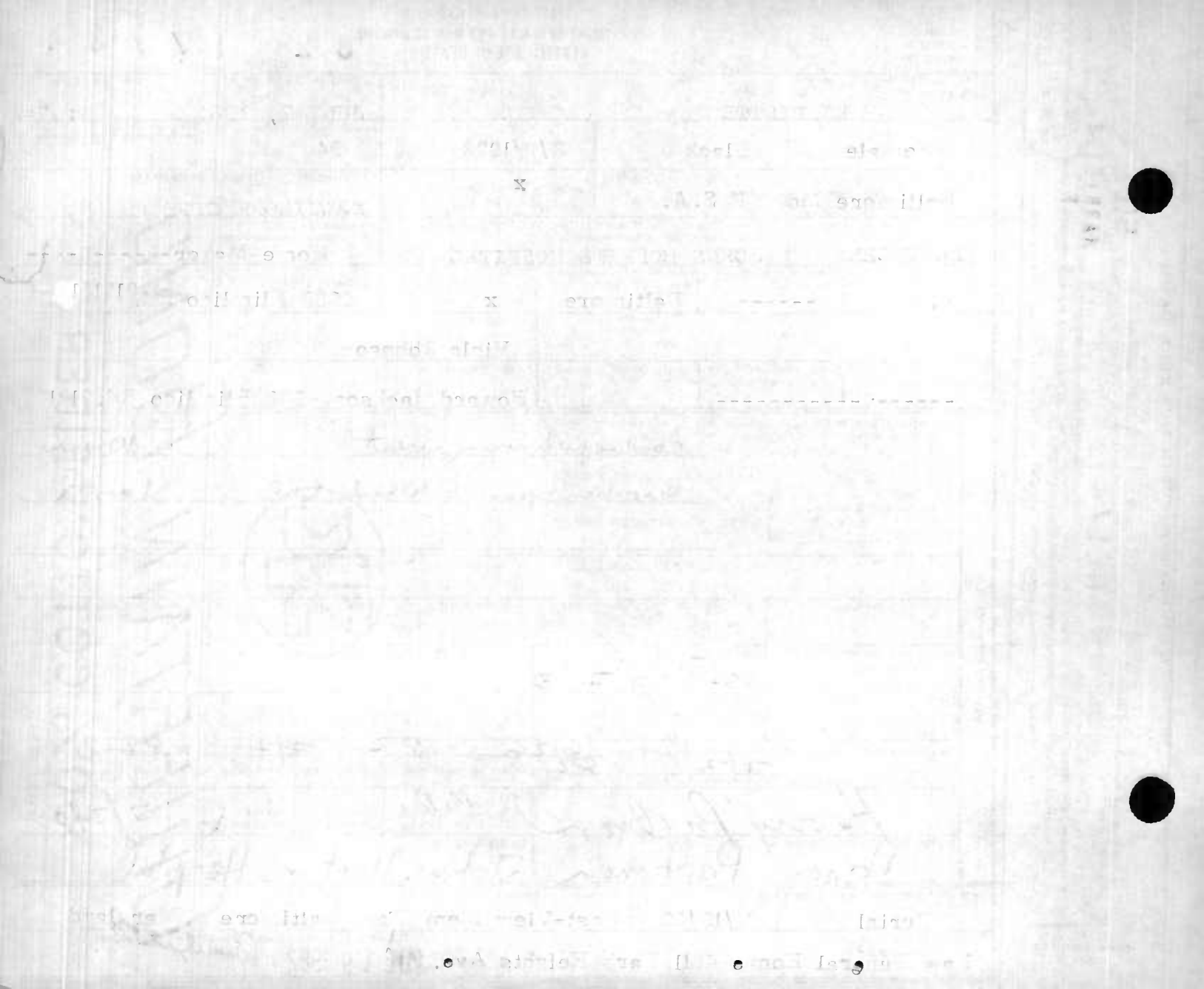
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|---|--------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 3 4 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRIETTE JACKSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 7 1982 | | 2b. HOUR 8:57^{PM} | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 6/9/1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md | | 7b. CITIZEN OF WHAT COUNTRY? U S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home-Maker | | 12b. KIND OF BUSINESS OR INDUSTRY -----0---- | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY ----- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4608 Plimlico Rd. 21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Johnson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) -----0----- | | 16b. SOCIAL SECURITY NO. ----- | | 17. INFORMANT ADDRESS Howard Jackson, 4608 Plimlico Rd. 21215 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2875 IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) thrombocytopenia, GI bleed, CRF DUE TO, OR AS A CONSEQUENCE OF (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 1 month | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:57 P.M. 7 7 1982 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/7/82 , 19 82 , to 7/7/82 , 19 82 , that (I) (we) last saw the deceased alive on 7/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Henry Partman | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/7/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Partman | | | | 22e. ADDRESS Johns Hopkins Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/15/82 | | 23c. NAME OF CEMETERY OR CREMATORY East-View Mem Pk | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Law Funeral Home | | | | ADDRESS 4611 Park Heights Ave. | | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S DEPUTY JUL 19 1982 | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the records after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must perform an autopsy.)

DHMH: 16 60M 7/73
(VR A 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 3 5 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2. DATE OF DEATH | | | | 2b. HOUR | | | |
| Tarleton Custis Jackson | | 7/26/82 | | | | 11:15 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | |
| Male | | Black | | 8 10 15 | | 67 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | USA. | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | DELAIR CONVALESCENTIUM | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Md. | | Baltimore | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 433 E. Pennsylvania | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| UNKNOWN | | Emma Jackson | | Yes | | | | | |
| 16a. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17b. ADDRESS | | | | | |
| 228-12-1766 | | Beatrice Tyler | | 431 E. Pennsylvania | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: (1) METASTATIC CARCINOMA OF 1850 IMMEDIATE CAUSE (a) (b) PROSTATE (c) WASTING 27 TO #1 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from | | 22b. SIGNATURE | | 22c. ADDRESS | | 22d. DATE SIGNED | | | |
| above. (I) (we) (we and) (all) did not view the body after death. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 7/26/82 | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS | | | | | | | |
| 30 SCOTT ADAM MD | | Crownville, MD (RIVERS) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| BURIAL | | 7-30-82 | | Crownville | | Crownville, Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| W. March FH. | | JUL 28 1982 | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

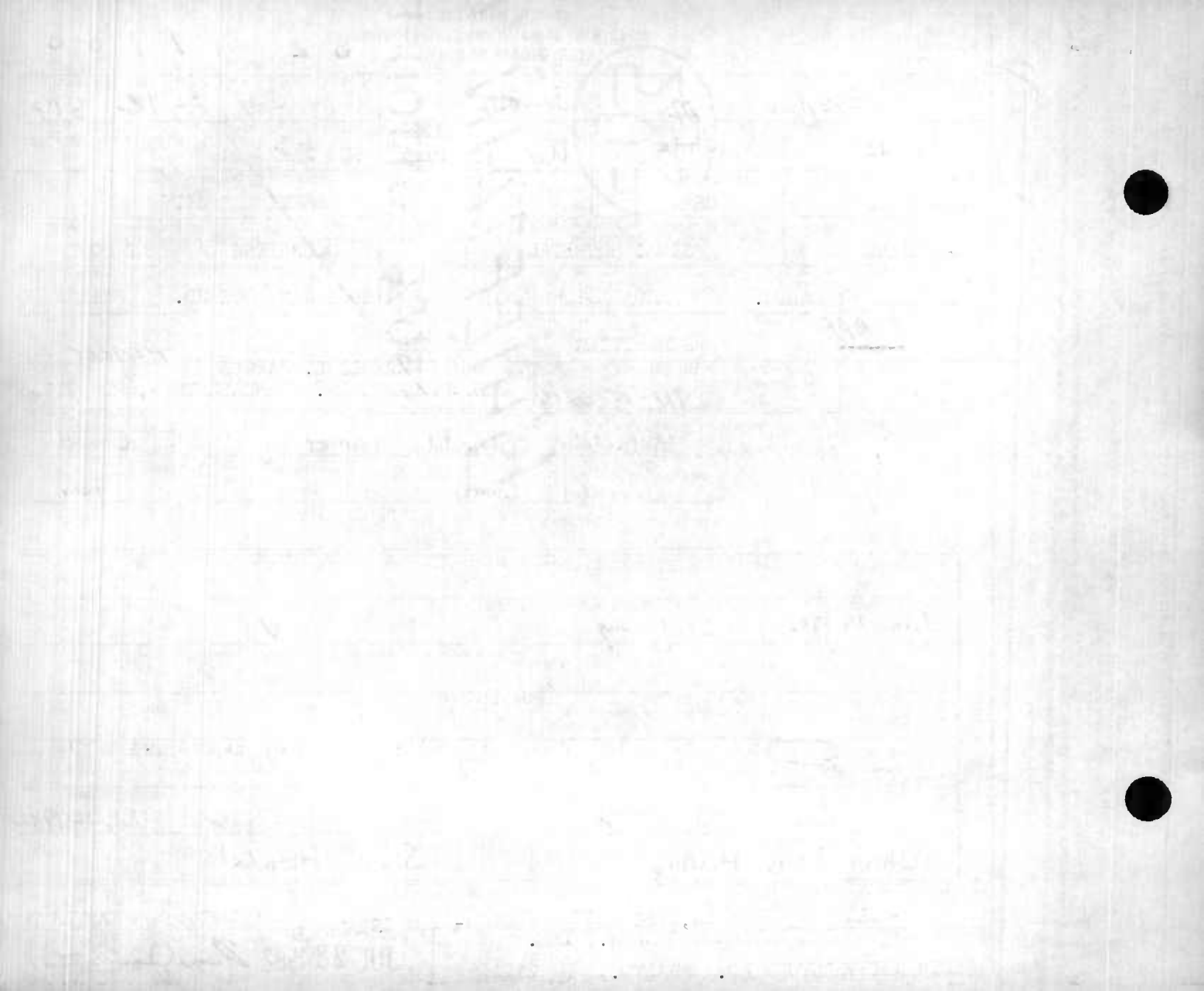
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 3 6

REG. NO.

1 - FOR
STATE
REGISTRAR

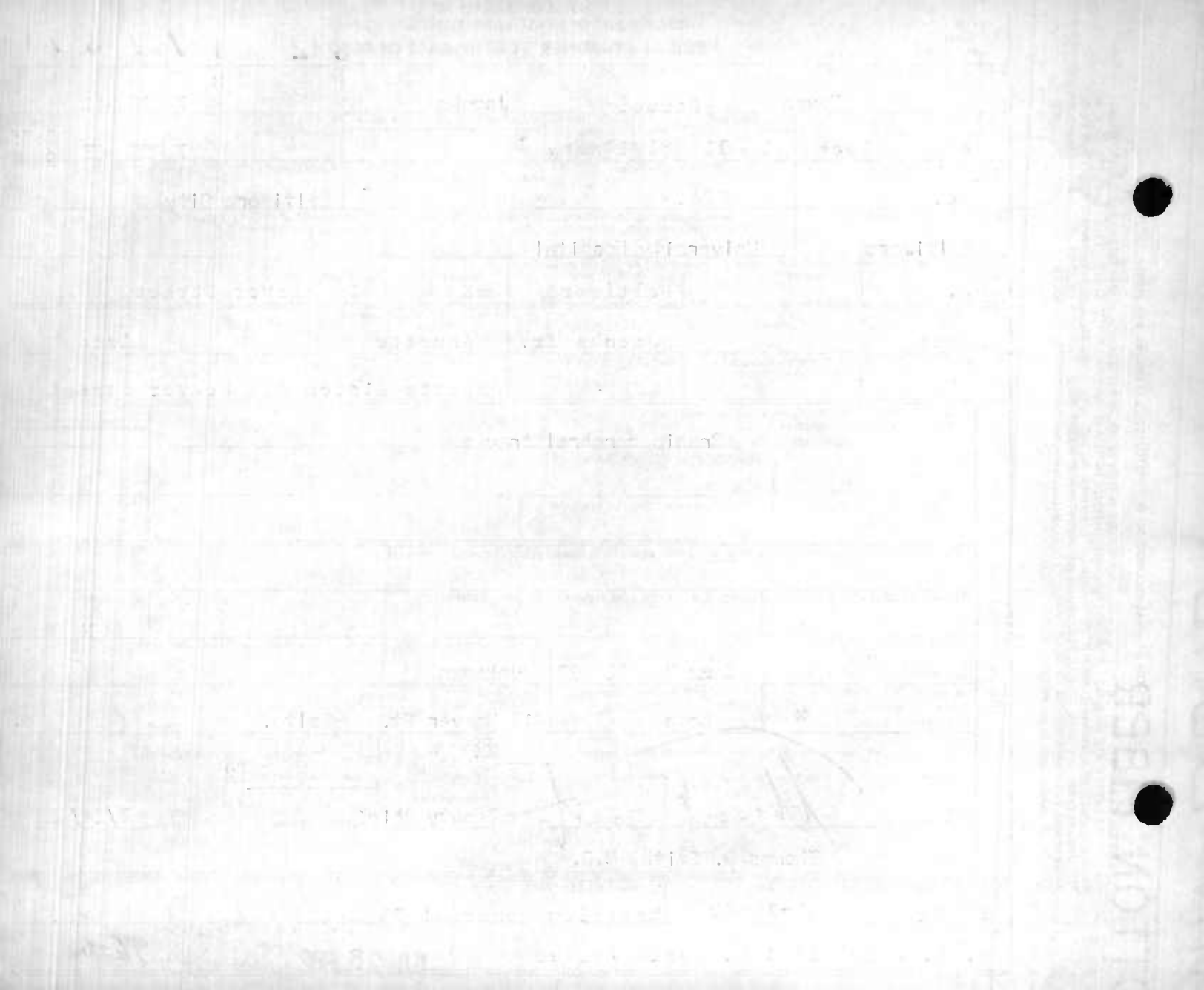
| | | | | | | | | | | |
|---|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn M. Jacobs | | | 2a. DATE OF DEATH MONTH DAY YEAR July 22 1982 | | | 2b. HOUR 6:15AM | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 10 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 55 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 55 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN RANDALLSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3831 JANBROOK RD. #21133 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MAX MORRIS SCHWEITZER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE ALBERT | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 111-18-6216 | | 17. INFORMANT ARNOLD L. JACOBS 3831 JANBROOK RD. RANDALLSTOWN, MD 21133 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1540 Metastatic colorectal cancer IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Colorectal Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16 | | | | | | | | | | |
| 19a. DATE OF OPERATION June 29, 1982 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Stationary | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 6 19 82 , to July 22 19 82 , that (I) (we) last saw the deceased alive on July 22 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Chun-Kang Huang | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED July 22, 1982 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chun-Kang Huang | | | 22e. ADDRESS Sinai Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE JULY 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY MIKRO KODESH-BETH ISRAEL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17737 | |
|--|--|---------|--|------------------|--|--|--|-----------------------|---|---------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | | 2c. DATE PRONOUNCED DEAD | | |
| Tavon Samuel Jacobs | | | 7 23 1982 | | | M | | | 7 23 1982 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | |
| Male | | Black | | 1 31 81 | | 1 1/2 yr. | | MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Md. | | | USA. | | | | | | Baltimore City, MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | University Hospital | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | | | | Baltimore | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b. SOCIAL SECURITY NO. | | |
| James | | | Annette Alston | | | No | | | UNKNOWN | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 19. ADDRESS | | | 20. AUTOPSY? | | |
| Annette Alston | | | PART 1 DEATH WAS CAUSED BY: | | | 419 Heaver Street | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| | | | IMMEDIATE CAUSE (a) Cranio cerebral trauma | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (b) | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | |
| | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 6 7 20 1982 | | | unknown | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION | | | 21g. CITY OR TOWN | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> | | | home | | | 419 Heaver St. | | | Balto. | | |
| 22a. I certify that I took charge of the remains described above, held on | | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| death resulted from: | | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| BURIAL | | | 7-28-82 | | | Eastview Memorial Pk | | | BALTIMORE, Md. | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Wm. C. March | | | JUL 26 1982 | | | James J. Nathan | | | | | |
| NAME | | | ADDRESS | | | | | | | | |
| 1101 E. North Avenue | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 7 3 8 | |
|--|--|---|--|--|---|--|---|---|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Jacob J. Jaffa | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/11/82 | | | 2b. HOUR 9⁴² A.M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUGUST 22, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6015 SEFTON AVE. 21214 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL JAFFA | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWII-ARMY 218-18-1655 | | 17. INFORMANT ADDRESS MRS. ANN JAFFA 6015 SEFTON AVE. 21214 | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured aortic aneurysm 4413 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/11/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aortic aneurysm | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 7/11/82 to 7/11/82 , that (1) (he) lost saw the deceased alive on 7/11/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Naslund | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/11/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naslund | | | | 22e. ADDRESS Baltimore City Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 13, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CEM. MORELAND MEM. PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 14 1982 | | 25b. REGISTRAR'S SIGNATURE James J. ... | | | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove to-ban papers. Pages 1 and 2 should be filed with the registrar after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

NOTIFICATION OF PAYING PERSON

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 3 9 REG. NO. | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST BURLEY 4 JAMES | | 7 15 82 | | 6:09 AM | | | |
| 3. SEX 07 male | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 02 08 14 | | 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA, NC. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MD. HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN | | 12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN | | | |
| 13a. STATE MD | | 13b. COUNTY BALT. | | 13c. CITY OR TOWN BALT | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1102 HARLEM AVE | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID JAMES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR "OTHER") NO | | 16b. SOCIAL SECURITY NO. 242-09-3096 | | 17. INFORMANT Helen E. Jefferson 805 Fitzgerald 3702 WILKINSON AVE BALTIMORE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) 5 DAYS | | | | | | | | BETWEEN ONSET AND DEATH 30 MINUTES | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE | | | | | | | | | |
| 19a. DATE OF OPERATION — | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) — | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — — | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/10/82, 19 82, to 7/15/82, 19 82, that (I) (we) lost saw the deceased alive on 7/15/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE SA Henry, MD | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/15/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Henry, MD | | 22e. ADDRESS University of Maryland Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Ave. | | 25a. DATE FILED BY REGISTRAR JUL 19 1982 | | | | | |

10/10/1919

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24-00-010 24-00-010 24-00-010

ACUTE MYOCARDIAL INFARCTION

None

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 4 0
REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR P | |
| | | Barnett Fort January | | July 15, 1982 | | 11:15 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 - 8 - 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Mexico | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice Pres. | | 12b. KIND OF BUSINESS OR INDUSTRY Publishing | |
| 13a. STATE Maryland | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Loch Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME (TYPE OR PRINT) Frank Barnett | | 15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Olivia Fort | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | |
| 16b. SOCIAL SECURITY NO. 212,03,1862 | | 17. INFORMANT ADDRESS Doris E. January (Wife) Same as 13c | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cocaine Abuse DUE TO, OR AS A CONSEQUENCE OF (b) Severe Asthma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 females 13 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Aug '69, 19, to 7/14/82, 19, that (1) (we) lost saw the deceased alive on 7/14/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (and) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John J. Messina, M.D. | | DEGREE | | 22c. DATE SIGNED 7/16/1982 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Messina, M.D. | | 22f. ADDRESS 7401 Osler Drive, Towson, Maryland 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 7/17/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Walter Brooks Bradley, Inc. Balto., Md. 21222 | | | | 25. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 82 17741

1. FOR
STATE
REGISTRAR

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|--|--|---|--|---|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Henry Jefferson | | 2a. DATE OF DEATH MONTH DAY YEAR 7/15/82 | | 2b. HOUR 11:50 AM | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 4 15 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore (City) MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |

| | | | | | |
|---|--|--|---|---|---|
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 5610 Key Avenue |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Jefferson | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Jefferson | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 251-14-7424 | | 17. INFORMANT ADDRESS Maggie Nelson 5610 Key Avenue | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation, Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF, (b) S/P Cardiac Arrest on 7/14/82 DUE TO, OR AS A CONSEQUENCE OF, (c) ARDS, Comp from S/P Cardiac Arrest 7/14/82, Renal Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. S/P Gastrectomy | | |

| | | | |
|--|---|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

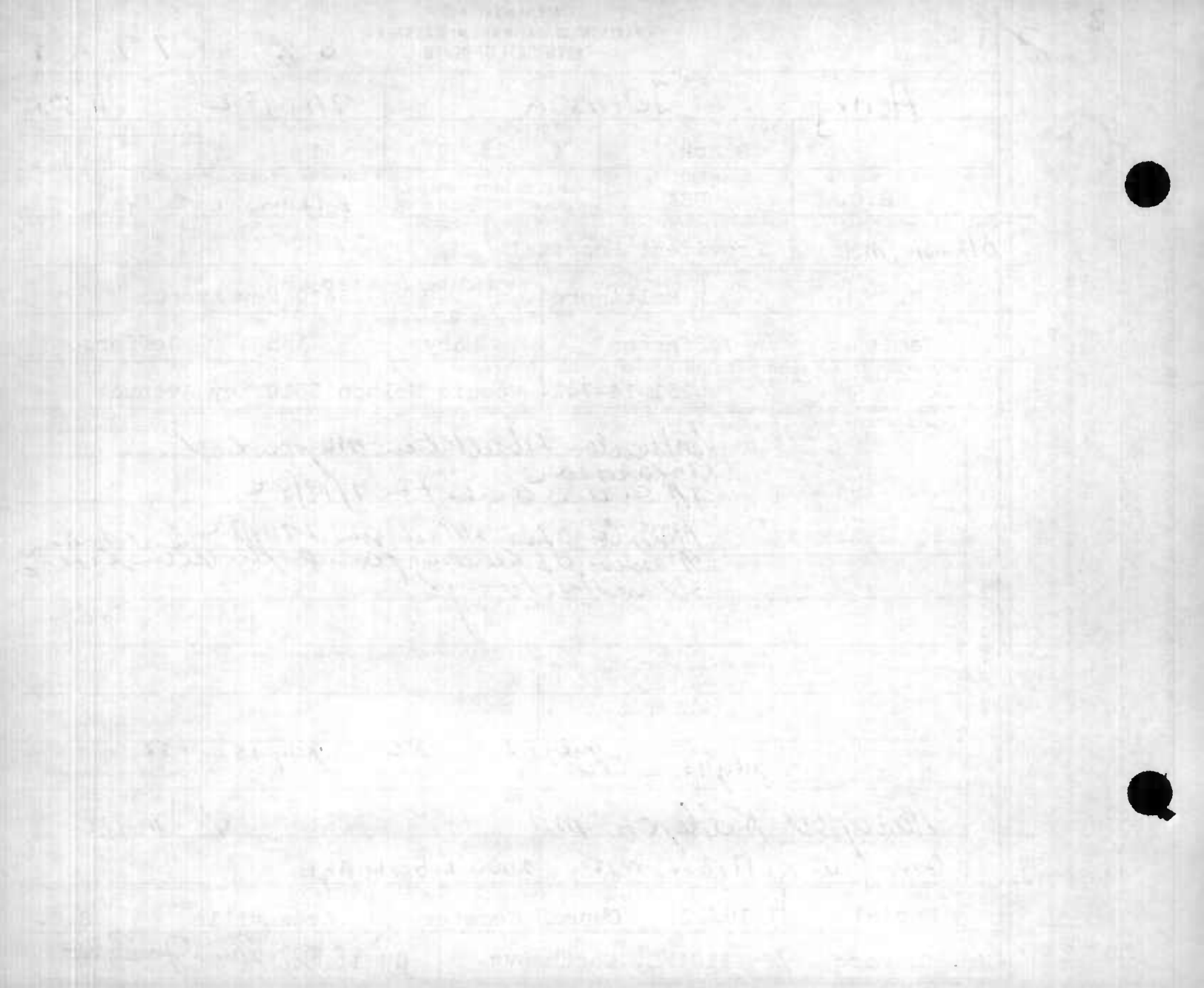
| | | | |
|--|--|---|------------------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from July 2 , 19 82 , to July 15 , 19 82 , that (I) (we) last saw the deceased alive on July 15 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE DEGREE Garry W. Killipon, M.D. | 22c. DATE SIGNED 7/15/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Garry W. Killipon, M.D. | | 22e. ADDRESS 2600 Liberty Hgts. | |

| | | | |
|--|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/19/82 | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Greenville S.C. |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
| ADDRESS 1101 E. North Ave. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



JUL 19 1982

JUL 19 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 7 4 2 REG. NO. | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eliza Jeffries | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 19 1982 2b. HOUR 1821 M | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 8/28/1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY ***** | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION) 13b. STATE 13c. COUNTY Virginia Prince Ed., Farmville Va | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 601 Chambers St., | |
| 14. FATHER'S NAME FIRST MIDDLE LAST T Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Meadose | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 219-01-5056 | | 17. INFORMANT ADDRESS Ms. Alene Jeffries Baltimore, Md. 21217 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 DAYS 1 MONTH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY FAILURE | | | | | | | |
| 19a. DATE OF OPERATION 6/2/82; 7/1/82; 7/1/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BONEC NECROSIS | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from JUNE 30 , 19 82 , to JULY 19 , 19 82 , that (1) (we) lost saw the deceased alive on JULY 19 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE CRANE PETERS | | | | DEGREE MD | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRANE PETERS | | | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY Midway Ch Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Farmville, Virginia | |
| 24. FUNERAL DIRECTOR NAME Bland-Reid Funeral Home Farmville, Va. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR James J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 4 3 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Ernest Clifton Jenkins | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 23 82 | | 2b. HOUR 3:45 P.M. | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 10 5 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 34 N. Bernice Avenue | | | | 12. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Miller | | 12b. KIND OF BUSINESS OR INDUSTRY Conoco INC. | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 34 N. Bernice Ave. Baltimore, Maryland 21229 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Andrew Jacob Jenkins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Perry | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-09-5342 | | 17. INFORMANT Baltimore, Address Md. 21229 Ave. Mrs. Dorothy Berkshire 34 N. Bernice | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary artery CVA disease</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/17/82</u> 19 <u>1977</u> , to <u>7/23/82</u> 19 <u>1982</u> , that (I) (we) lost saw the deceased alive on <u>7/17/82</u> 19 <u>1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Sborofsky, M.D.</u> | | | | DEGREE | | 22c. DATE SIGNED 7/26/82 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sborofsky | | | | 22f. ADDRESS MD 4734 Park Heights Avenue, Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/28/82 | | 23c. NAME OF CEMETERY OR CREMATORY MEADOWBROOK Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Howard County Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Herbert E. Nutter Funeral Home 3035 North Ave Baltimore MD 21216 | | | | 25. DATE REC'D. BY REGISTRAR JUL 27 1982 | | 25b. REGISTRAR'S SIGNATURE James Van Natta | | | |

Department of Agriculture
Bureau of Plant Industry

Washington, D.C.

January 10, 1917

Dear Sir:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 7 4 4 | |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRIAN T JENKINS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7- 28- 82 | | 2b. HOUR 9:21P | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 1929 8- 31- 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL | | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY Truck Co. | | | |
| 13a. STATE Ind. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN - | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2818 Pennsylvania Ave. 21227 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Jenkins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Roberts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS Emma Jenkins 1106 Edwight St. 21225 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolus, myocardial infarction? DUE TO, OR AS A CONSEQUENCE OF (c) Severe COPD, CHF. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHF, ASCVD, Upper GI Bleeding | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7-28-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CHF | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-18 , 19 82 , to 7-28 , 19 82 , that (I) (we) last saw the deceased alive on 7-28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard Machado | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> RESIDENT <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7-28-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD MACHADO M.D. | | | | 22e. ADDRESS Agnes Hosann Baltimore Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 8-2-1982 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bltm. Md. A.A. Co. Ind. | | | | | |
| 24. FUNERAL DIRECTOR NAME John Cowan & Son INC. | | | | 24b. ADDRESS Balt. Md. 21223 | | 25a. DATE REC'D. BY REGISTRAR AUG 2 1982 | | 25b. REGISTRAR'S SIGNATURE James VanNathan | | | |

1948-56-85-7

1948-56-85-7

1948-56-85-7

1948-56-85-7

1948-56-85-7

1948-56-85-7

1948-56-85-7

1948-56-85-7

REAR MOTOR

1948-56-85-7



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8217745 | | | |
|--|--|--|--|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Walter Jenkins | | | | 2a. DATE OF DEATH MONTH 7 DAY 25 YEAR 82 | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH 1 DAY 30 YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 710 Edgewood St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST Monroe MIDDLE Brisco LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST Myrtle MIDDLE Jenkins LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 241-05-4757 | | 17. INFORMANT ADDRESS Thelma Jenkins 710 Edgewood St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest. 4029 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years. years. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Renal Failure; Dementia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 82 , to July 14 , 19 82 , that (I) (we) lost saw the deceased alive on July 14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Blair J. Andrew MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 27 July 1982 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Blair J. Andrew M.D. | | | | 22e. ADDRESS Baltimore City Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Addie Chapel Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Connelly Springs NC | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H ADDRESS 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 25b. REGISTRAR'S SIGNATURE James J. North | | | |

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 7 7 4 6

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | |
|--|---------|------------------|---|---|------------------------------------|--|--|----------------------------|--------------------------------------|---|--|-------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | | |
| MARGARET A. JOHANSEN | | | | | | 7-3-82 19 | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | |
| Female | White | 10/2/1910 | 71 YRS. | | | 7-3-82 19 | | | 9:35A M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | USA | | | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | | South Baltimore General Hospital | | | Housewife | | | Domestic | | | |
| 13a. STATE | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Joseph Hines | | | | | | Jennie (Unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| no | | | | | | 216-07-0032 | | | Henry O. Johansen Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute purulent peritonitis</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| 5672 | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | |
| (b) <u>ruptured viscus</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>) | | |
| | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| | | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE | |
| | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Virginia L. Dolan</u> | | | | TITLE (SPECIFY) <u>M.D. Assistant</u> | | | | DATE SIGNED <u>7-4-82</u> | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | |
| Virginia L. Dolan, M.D. | | | | 111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | STATE |
| Burial | | | 7/7/1982 | | Oaklawn Cemetery | | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| McCully Funeral Home Balto. Md., 21225 | | | | JUL 7 1982 | | | | Theresa Jean Whitham | | | | |
| 237 E. Patapsco Ave., | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1000

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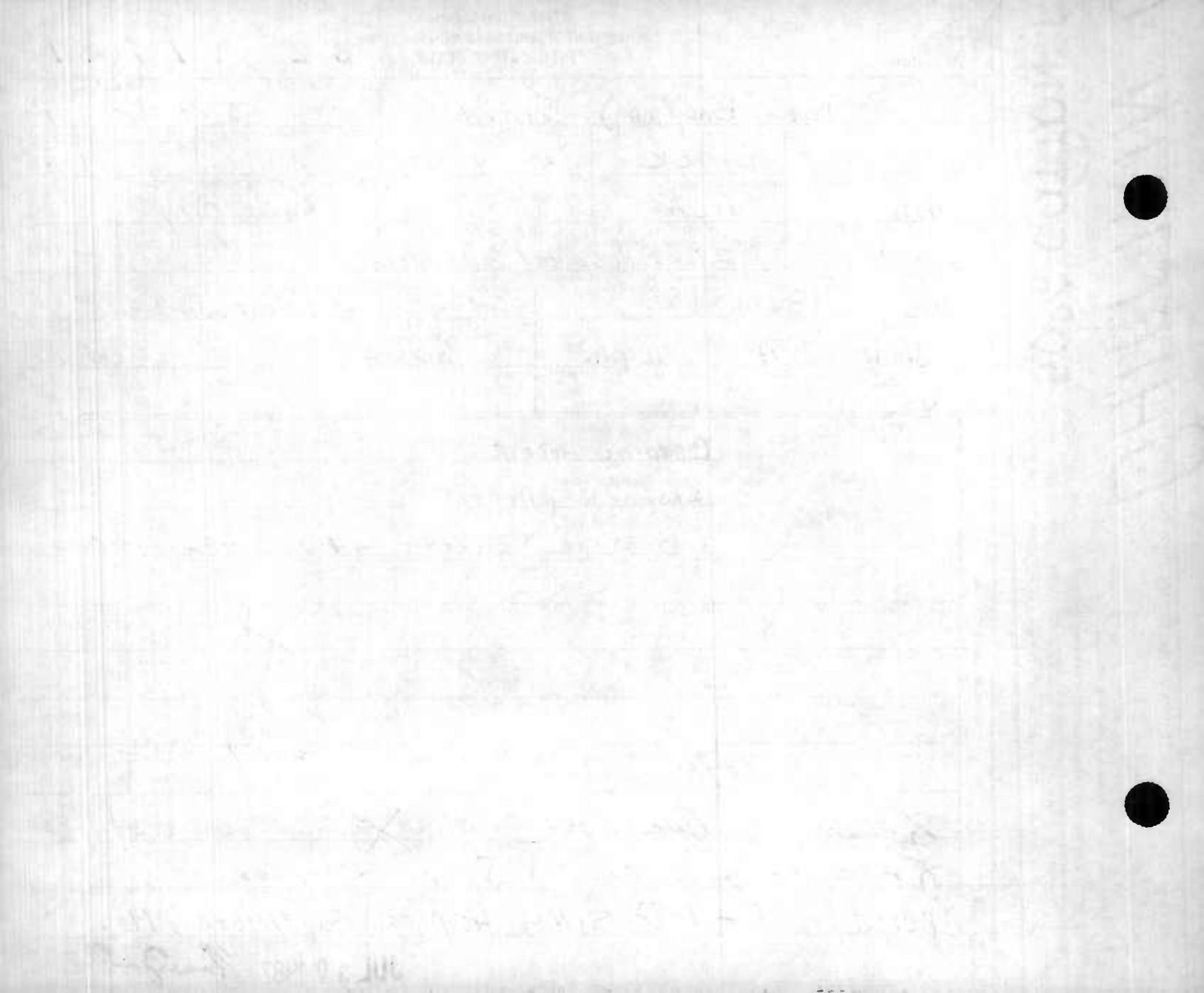


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified by item 1C.)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8217747 | | | |
|---|--|---|--|--|--|--|--|--|-----------------------------------|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 4 82 | | | | | | 2b. HOUR 1 P.M. | |
| I. DECEASED NAME (TYPE OR PRINT) Baby Boy (may) Johnson | | | | | | | | | | | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 5 4 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital Baltimore | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3111 Garrison Blvd. | | | | | |
| 13a. STATE md | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A WYNN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vanessa Johnson | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 7650 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Premature Delivery 24-25 weeks gestation | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 4 19 82 to May 4 19 82, that (I) (we) last saw the deceased alive on May 4 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Katherine Stevens MD | | | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/4/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE STEVENS | | | | | | 22e. ADDRESS SINAI HOSPITAL | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | | 23b. DATE 5-7-82 | | 23c. NAME OF CEMETERY OR CREMATORY SINAI HOSPITAL | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 7 4 8
REG. NO.

| | | | |
|--|--------------|--|--|
| 1. FOR STATE REGISTRAR ANNA | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA JOHNSON | | 2a. DATE OF DEATH MONTH DAY YEAR 7 18 82 | |
| 3. SEX F | 4. RACE B | 2b. HOUR 12 ⁴⁴ M | |
| 5. DATE OF BIRTH MONTH DAY YEAR 10 23 08 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 73 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO | | 7b. CITIZEN OF WHAT COUNTRY? USA | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD | |
| 10. CITY OR TOWN OF DEATH BALTO | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY BALTO | |
| 13c. CITY OR TOWN PALTO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 719 BAKER ST. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 189-16-3435 | |
| 17. INFORMANT ADDRESS Louise Fogle N.Y., N.Y. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>TRANSFUSION 2° to HEMATURIA</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CANCER OF BLADDER → CYSTECTOMY</u> | | | |
| 19a. DATE OF OPERATION 1974 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF BLADDER | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from 7/18/82 to 7/18/82, that (I) (we) last saw the deceased alive on 7/18/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (they) did not view the body after death.) | | | |
| 22b. SIGNATURE Dean Kane MD | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DEAN KANE MD | | 22e. ADDRESS SINAI HOSP OF BALTO | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/24/82 | |
| 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hartsfield Va. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | |
| 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 7 4 9 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Hilda Marie JOHNSON | | | | 7/8/82 | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 17 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long Green Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Milliner | | 12b. KIND OF BUSINESS OR INDUSTRY Millinery | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Albert G. Wiencke | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia K. Schultz | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO. 214-41-3147 | | 17. INFORMANT: nephew Edgar F. Wiencke, Jr., 103 Indian Lane, Annapolis, Md. 2103 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of colon</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this physician) attended the deceased from Jan 19 82, to 7/8/82, that (I) (we) lost saw the deceased alive on 6/29 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John W. Bowie MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/8/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Bowie - M.D. | | | | 22e. ADDRESS 500 W. University Pkwy - 21210 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/10/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto., Md. | |
| 24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Av., City 01 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | 25b. REGISTRAR'S SIGNATURE James Jan Kather | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

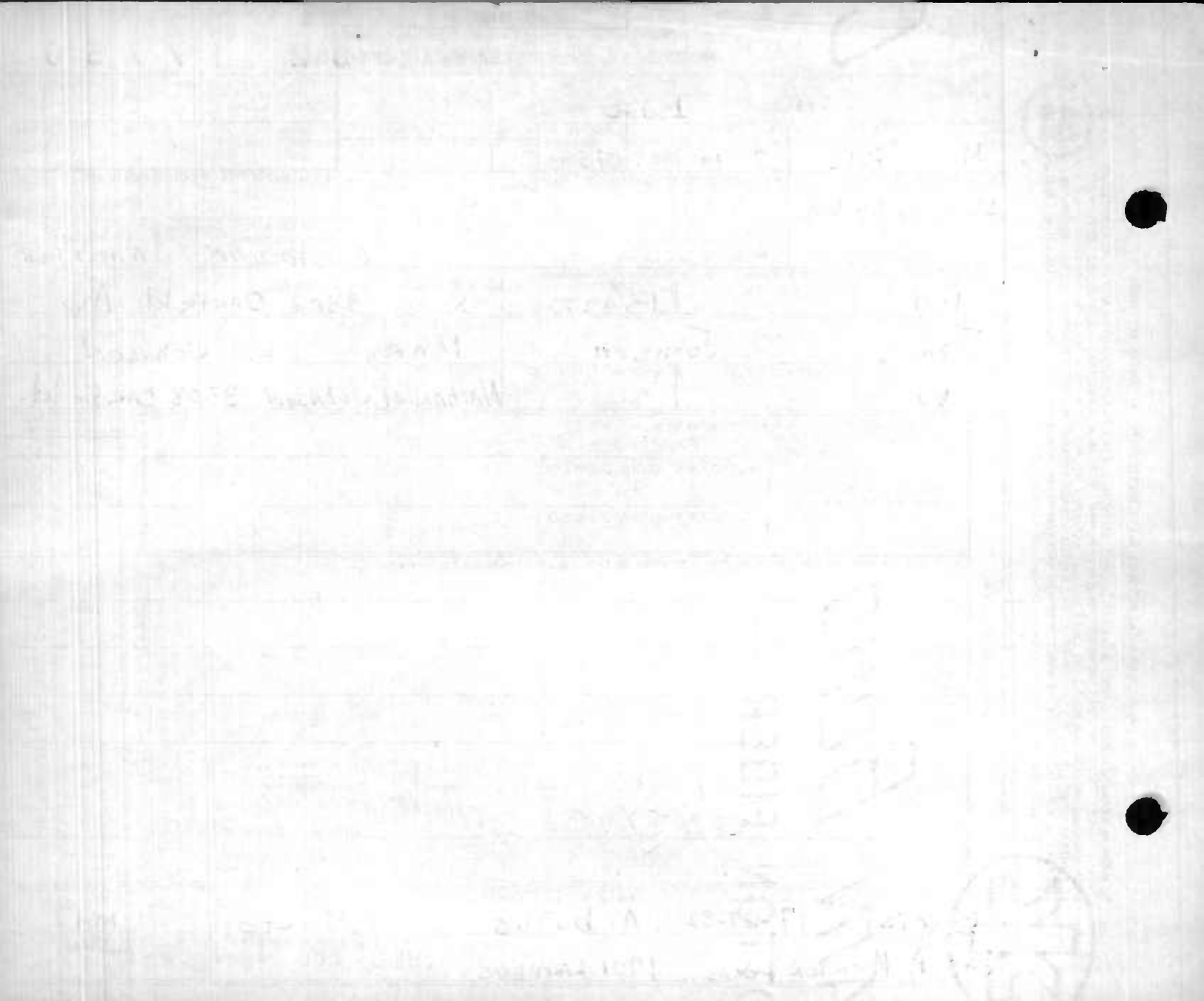
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7750

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | |
|---|---------|------------------|--|----------------|------------------|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF ESTI- MATED | | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | |
| Isaiah Isaac Johnson | | | 7 14 1909 | | | 7 23 19 82 | | | 7 23 19 82 | | | 10:25 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| M | Blk | 7 14 1909 | 73 YRS. | | | Elizabeth City N.C. | | | U.S.A. | | | Baltimore City | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | | 4206 Belvue Avenue | | | CUSTODIAN | | | WATER FRONT | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS | | |
| Md. | | | | | | BALTO | | | YES | | | 3308 Oakfield Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | |
| James Johnson | | | Mary E. Johnson | | | No | | | | | | NATHANIEL JOHNSON 3308 OAKFIELD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 1629 IMMEDIATE CAUSE (a) Carcinoma of lung | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | Hormez R. Guard, M.D. | | | | | | TITLE (SPECIFY) Assistant | | | DATE SIGNED 7/26/82 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | 7-27-82 | | | Arbutus | | | BALTO Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| JAS. A. MORTON & Sons | | | 1701 LAURENS | | | JUL 27 1982 | | | Charles J. Nathan | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 5 1 REG. NO. | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|--------------------------------|--|----------------|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE OF DEATH | | | | MONTH DAY YEAR | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James B. Johnson | | | | | | | | | | 7 12 82 | | | | 745 A.M. | | | |
| 3 SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 5 31 01 | | | | 6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | 13b. COUNTY — | | 13c. CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 2045 Bentloun St. | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST B. J. Johnson | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Blackwell | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-6253 | | 17. INFORMANT Mary Harris | | | | ADDRESS 2045 Bentloun St. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis from gangrenous foot 4442 DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Systemic emboli | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 4 days weeks | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CVA | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION 7/6/82 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ② femoral embolectomy | | | | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/18, 19 82, to 7/12, 19 82, that (I) (we) lost saw the deceased alive on 7/11, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE [Signature] DEGREE | | | | | | | | | | 22c DATE SIGNED 7/12/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald M. Lai | | | | | | | | | | 22e. ADDRESS Mercy Hospital | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/17/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | | | 23d LOCATION CITY OR TOWN COUNTY STATE Balto. mo | | | | | | | |
| 24 FUNERAL DIRECTOR NAME Wm. C. March F/H | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 1101 E. North Avenue 15 1982 | | | | | | | |
| ADDRESS 1101 E. North Avenue | | | | | | | | | | REGISTRAR'S SIGNATURE Frances Jan Nathan | | | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7752

1- FOR
STATE
REGISTRAR

| | | | | |
|--|-----------------------------|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) Joanne (Joann) | | 2. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 7 7 1982 | | 2b. HOUR 12:02 M P M |
| 3. SEX F | 4. RACE B | 5. DATE OF BIRTH MONTH DAY YEAR 10 12 54 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 27 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3446 Chessell Court | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MD | | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Willie Johnson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 217-66-8751 | | 17. INFORMANT ADDRESS Vivian Johnson 2601 Liberty Hgts. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder 7803 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE <i>Virginia L. Dolan</i> | | TITLE (SPECIFY) Assistant | | DATE SIGNED 7/7/82 |
| EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan., M.D. | | ADDRESS 111 Penn St. Balto., MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/13/82 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. MD | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March P/H | | ADDRESS 1101 E. North Ave. | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Nathan</i> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 7 5 3 | | | | |
|---|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leona S. Johnson | | | | 7 13 82 | | | | M |
| 3 SEX Female | | 4 RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 5 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, Maryland MD | | |
| 10 CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS 2729 Ellicott Drive Baltimore, Maryland 21216 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST F. H. Hull | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bell | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO 214-01-0737B | | 17. INFORMANT ADDRESS Baltimore, Md. 21216 Mrs. Jessie Mae Conway 2214 Poplar | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HT DISEASE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1982</u> , to <u>July 13, 1982</u> , that (I) (we) lost saw the deceased alive on <u>July 13, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Gilbert Banfield MD</u> | | | | DEGREE | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Gilbert Banfield | | | | 22e. ADDRESS MD 722 North Fulton Avenue, Baltimore, Md 21217 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Poplar Spring Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lincolnton, North Carolina | | |
| 24. FUNERAL DIRECTOR NAME Helen E. Nutter Funeral Home | | 24b. ADDRESS Baltimore 3035 W. NORTH AVE. | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles J. Van Kesteren | | | | | | | | |

RECEIVED



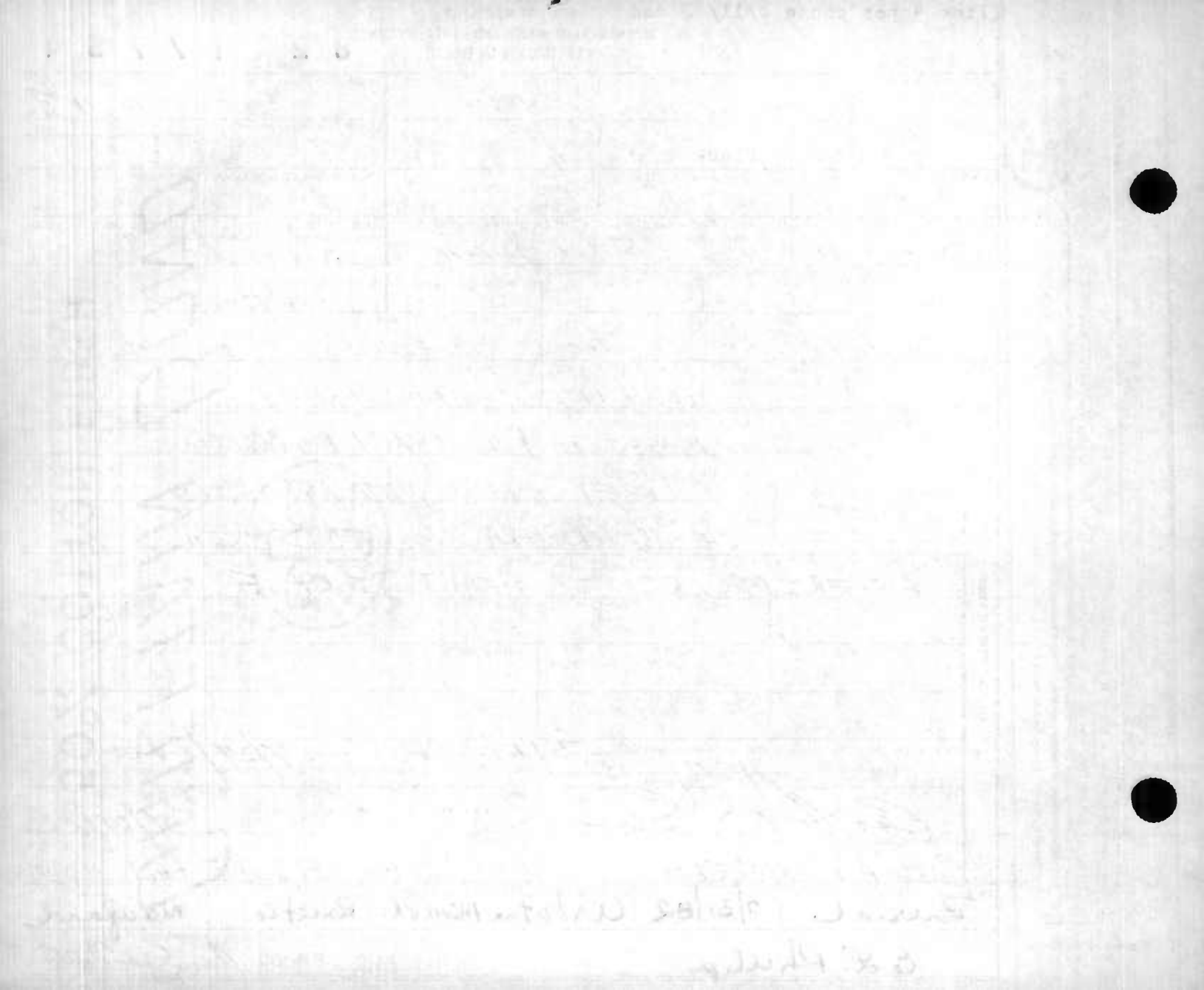
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|
| Itme 4 per phone 8/11/82 dad STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 82 17754 | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) LILLIAN M. JOHNSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 27 1982 | | | | | 2b. HOUR 11 AM | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 09-03-07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | | 13b. COUNTY Balti. | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 5315 Borworth Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Fredrick Puider | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA Boyer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 216-12-8070 | | 17. INFORMANT Chart (patient) | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) LEFT ABOVE KNEE AMPUTATION DUE TO, OR AS A CONSEQUENCE OF (c) SEVERE PERIPHERAL VASCULAR DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1/82 to 7/27/82 that (I) (we) last saw the deceased alive on 7/27/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE CARL A. S. SAMUELS | | | | | | | | 22c. DATE SIGNED 7/27/82 | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) CARL A. S. SAMUELS | | | | | | | | 22c. ADDRESS 6911 PARK HEIGHTS AVE BALT. MD 21215 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pl. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltic. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME E. L. Phillips | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 2 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | | | |



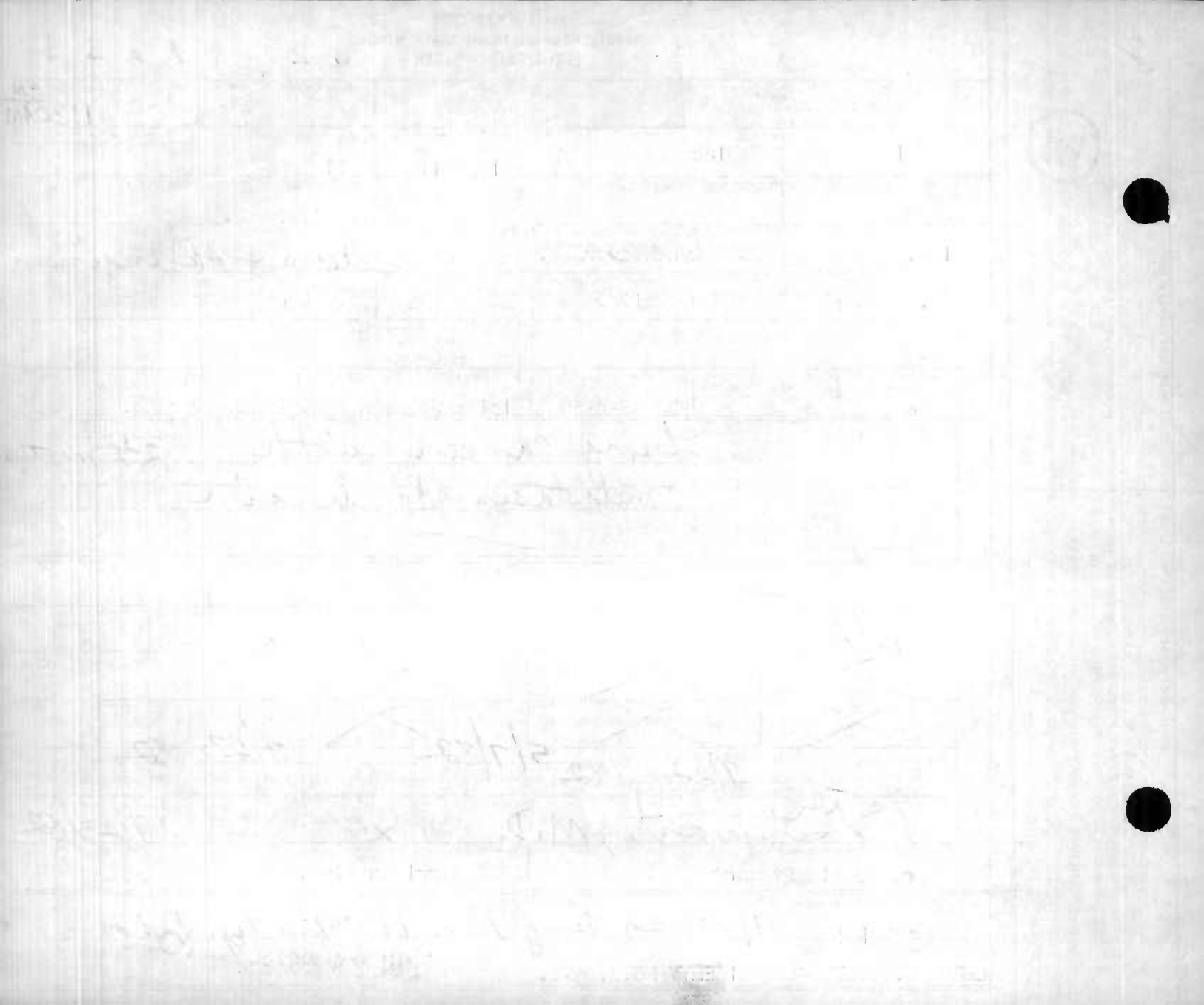
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 5 5 REG. NO. | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|---|--|----------------------|--|----------------|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DECEASED NAME (TYPE OR PRINT) | | | | 2b. DATE OF DEATH MONTH DAY YEAR | | | | 2c. HOUR AM PM | | | |
| LOVETTE | | | | | | JOHNSON | | | | 7 23 82 | | | | 1:30 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN. | | | | | | | |
| Male | | Black | | 7 17 11 | | 71 YRS. | | | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| New York | | USA | | | | Balto. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Balto. | | 3509 Lynchester Rd. | | | | | | Steam & A/C Engineer | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS | | | | | | | | | |
| 13a. STATE Md. | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | | | 3509 Lynchester Road | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | | | | | | | | | | |
| unknown | | | | | | unknown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| no | | | | | | 578-05-4660 | | Eloise Johnson 3509 Lynchester Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lung Cancer with</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 months</u> | | | | | | | |
| 1629 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastasis to brain</u> | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| N/A | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1E, PART I, OR PART 2) | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7/22</u> 19 <u>82</u> to <u>7/23</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>7/22</u> 19 <u>82</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 23a. SIGNATURE <u>Dr. Donald Stewart, M.D.</u> | | | | | | DEGREE | | 23b. DATE SIGNED <u>7/23/82</u> | | | | | | | | | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 23d. ADDRESS | | | | | | | | | | | |
| Dr. Donald Stewart | | | | | | 2300 Garrison Blvd. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | |
| Burial | | | | 7/30/82 | | Lung Mem. Pk. | | Balto. Co. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | | | 25a. DATE REC'D. BY REGISTRAR (REGIST. AND SIGNATURE) | | | | | | | | | |
| LEROY O. DYETT 4600 LIBERTY HTGS. AVE. | | | | | | | | JUL 26 1982 | | | | | | | | | |

1511 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 5 6

REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST | | 7 14 82 | | 11 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | Black | | 6 6 04 | | 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Virginia | | U.S.A. | | | | Balto. City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Balto. | | JL Deaton Med. Ctr. 611 S. Choptank | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | Balto | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 17. INFORMANT ADDRESS | |
| Lawson | | Washington | | Mary | | Frances | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1800 | | DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma of the endocervix | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| None | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12, 19 82, to 7/14, 19 82, that (I) (we) last saw the deceased alive on 7/14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| Dona E. King MD | | | | | | 7/15/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Dona E. King MD | | J.L. Deaton Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 6/17/82 | | Arbutus | | Balto. Md. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Leroy A. Byett 4600 Liberty Hgts | | JUL 15 1982 | | Frances VanNathan | | | |

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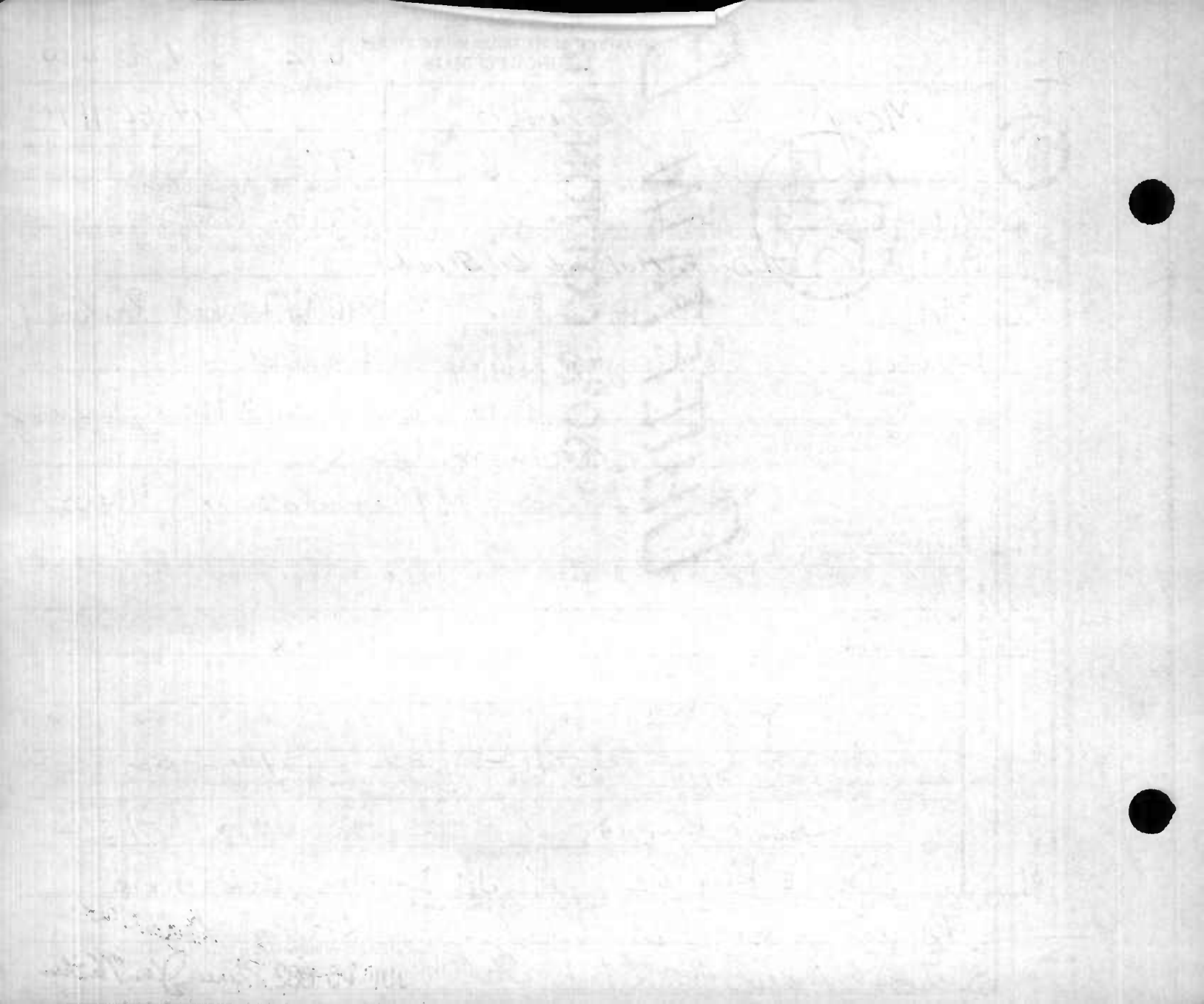
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 5 7 REG. NO. | |
|---|--|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NAOMI R. JOHNSON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 3 '82 | | | 2b. HOUR 5⁴⁸ P^M | | | |
| 1. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 8 17 14 | | 6. AGE (IN YEARS [LAST BIRTHDAY]) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE CITY HOSP D BLDG. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY News American | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY - 13c. CITY OR TOWN Balto. | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4210 Parkmont Ave. | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Christian Johnson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence A. Lawson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO 215-03-6568 | | 17. INFORMANT ADDRESS Sarah J. Reinsfelder 2032 Lanvale St. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 2500 DUE TO, OR AS A CONSEQUENCE OF (b) PERMANENT ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DILATED MYOCARDIUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 2/5/81 , 19 81 , to 7/3 , 19 82 , that (we) last saw the deceased alive on 7/3 , 19 82 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) will view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert A. Weisman MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 7/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT A. WEISMAN MD | | | | | 22e. ADDRESS BALTIMORE CITY HOSP. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7-9-82 | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME John C. Miller Inc. | | | | | ADDRESS 6415 Belair Rd. | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | | | |

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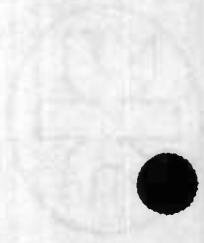
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 7 5 8 | |
|---|--|--|--|---|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBERT F. JOHNSON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-9-82 | | 2b. HOUR 7:10 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12-24-1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. City | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY B & O R.R. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Johnson | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Meyd | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-03-8018 | | 17. INFORMANT ADDRESS Mrs. Mary E. Johnson - 4606 Asbury Ave. 21206 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arrhythmia (Atrial fibrillation)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27" | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Acute Diverticulitis, Confined perforation, Congestive Heart failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION 7-8-82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Diverticulitis, Confined perforation | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>JUNE 26</u> , 19 <u>82</u> , to <u>JULY 9</u> , 19 <u>82</u> that (1) (we) lost saw the deceased alive on <u>JULY 9</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Colleen M. Fitzpatrick MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 7-9-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) COLLEEN M. FITZPATRICK M.D. | | | | | | 22e. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-13-82 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md. | | | | | |
| 24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd., -21206 | | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 12 1982 [Signature] | | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 7 2 1 7 7 5 9 REG. NO. | |
|---|--|--|--|---|--|---|--|--|--------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BABY BOY JONES "B" | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4 28 82 | | | 2b. HOUR 3 A M | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4 27 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 11 - | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5724 NASCO PLACE | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CALVIN JONES | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROLYN JONES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS KATHLEEN STEVENS, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 7651 DUE TO, OR AS A CONSEQUENCE OF (b) prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) premature birth | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 hr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 27 , 19 82 , to April 28 , 19 82 , that (I) (we) lost saw the deceased alive on April 28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Kathleen Stevens MD | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/28/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHLEEN STEVENS | | | | | | 22e. ADDRESS Sinai Hospital of Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY Sinai | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE Russell J. North | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 13a-e per phone 8/3/82 dad STATE OF MARYLAND

FOR
1 - STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 6 0
REG. NO.

| | | | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Baby Girl Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR 2/10/82 | | 2b. HOUR 8:17 P.M. | | | | | | | |
| 3. SEX F | | 4. RACE BL | | 5. DATE OF BIRTH MONTH DAY YEAR 2 4 82 | | 6. AGE (IN YEARS LAST BIRTHDAY) 6 DAYS 00 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 0 6 | | 7. IF UNDER 24 HRS. HOURS MIN. 0 0 | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 9. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH CITY MD. | | | | | | |
| 12. CITY OR TOWN OF DEATH Baltimore | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital | | | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT | | 15. KIND OF BUSINESS OR INDUSTRY | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE md 16b. COUNTY Baltimore 16c. CITY OR TOWN Baltimore | | | | | | 17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. STREET ADDRESS 4050 Park Heights Belvedere Cedar Ridge | | | | |
| 19. FATHER'S NAME FIRST MIDDLE LAST Michael Liffort | | | 20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annette Jones | | | | | | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 22. SOCIAL SECURITY NO. none | | | 23. INFORMANT ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> 759-1 DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple congenital anomalies</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>82</u> , to <u>2/10</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Bonnie Epstein MD | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 2/10/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS Sinai Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY Sinai Hosp | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25. DATE REC'D. BY REGISTRAR JUL 30 1982 | | 25. REGISTRAR'S SIGNATURE Theresa J. [Signature] | | | | |

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WALLACE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8217761
REG. NO.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) JOHN ARRON O JONES | | 2a. DATE OF DEATH MONTH DAY YEAR 7 21 82 | | 2b. HOUR 11:30 AM | |
| 3 SEX MALE | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 7 6 82 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 15 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | 12b. KIND OF BUSINESS OR INDUSTRY NONE | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY BALTO. | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 785 CARROLL ST | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ASHLAND JONES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHEILA A BOONE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. — | |
| | | 17. INFORMANT CHAIR (MOTHER) ABOVE. | | ADDRESS | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> 5609 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION 7/18/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BOWEL OBSTRUCTION | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I, this hospital) attended the deceased from 7/15/82, to 7/21/82 that (I/we) last saw the deceased alive on 7/21/82 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Edward J. Doolin | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD J. DOOLIN | | 22e. ADDRESS 925 GREENE ST BALTO MD 21212 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk | | 23d. LOCATION OR TOWN BALTIMORE COUNTY MD. STATE | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/W 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE | |

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows]

DATE: 1/18/82
[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 17762 | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice V. Jones</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 12, 1982</i> | | | |
| 1b. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>3-27-20</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1841 Covington ST.</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Quarter girl</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Reptile Rec.</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Bronislaw KACPURA</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bronislaw KACPURA</i> | | 13e. STREET ADDRESS <i>1841 Covington ST.</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-09-9023</i> | | 17. INFORMANT ADDRESS <i>John Mark-1841 Covington ST</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic disease</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1971</i> , 19____, to <i>July 12</i> , 19____, that (I) (we) last saw the deceased alive on <i>Jan. 26</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Ricardo Lotada</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>7/14/82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICARDO LOTADA</i> | | | | 22e. ADDRESS <i>1222 South Charles St Baltimore, Maryland 21230</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/15/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>My Cross Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Charles L. Stevens Funeral Home, Inc.</i> | | | | ADDRESS <i>1501 E. Fort Ave.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 16 1982</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>James Van Nuthan</i> | | | |

10. 10. 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 7 6 3 REG. NO. | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLIFTON H. JONES | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 15 82 | | 2b. HOUR 11:30 AM | |
| 3. SEX M | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 1 - 22 - 97 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY 13c. CITY OR TOWN Balto | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5131 Penbridge Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JONES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWI | | | |
| 16b. SOCIAL SECURITY NO. 218 18 6189 | | 17. INFORMANT Ida Neal | | ADDRESS 4733 Park Heights Ave | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 1519 DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastric carcinoma - metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>11/82</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (If this hospital) attended the deceased from <u>July 12</u> , 19 <u>82</u> , to <u>July 15</u> , 19 <u>82</u> , that <u>X</u> (we) lost <u>saw the deceased alive on July 15</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <u>he (we) (did) (did not)</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>R. B. Williams</u> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/15/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RONAN B. WILLIS M.D.</u> | | 22e. ADDRESS <u>3900 Loch Raven Blvd. Baltimore, Maryland</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>7-21-82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CROWNSVILLE NAT'L</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Crownsville Md</u> | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <u>VERNON R. Bailey 1348 N. Calhoun St.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 20 1982</u> | | 25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u> | |

60-1-1-0

STANDARD FORM NO. 64



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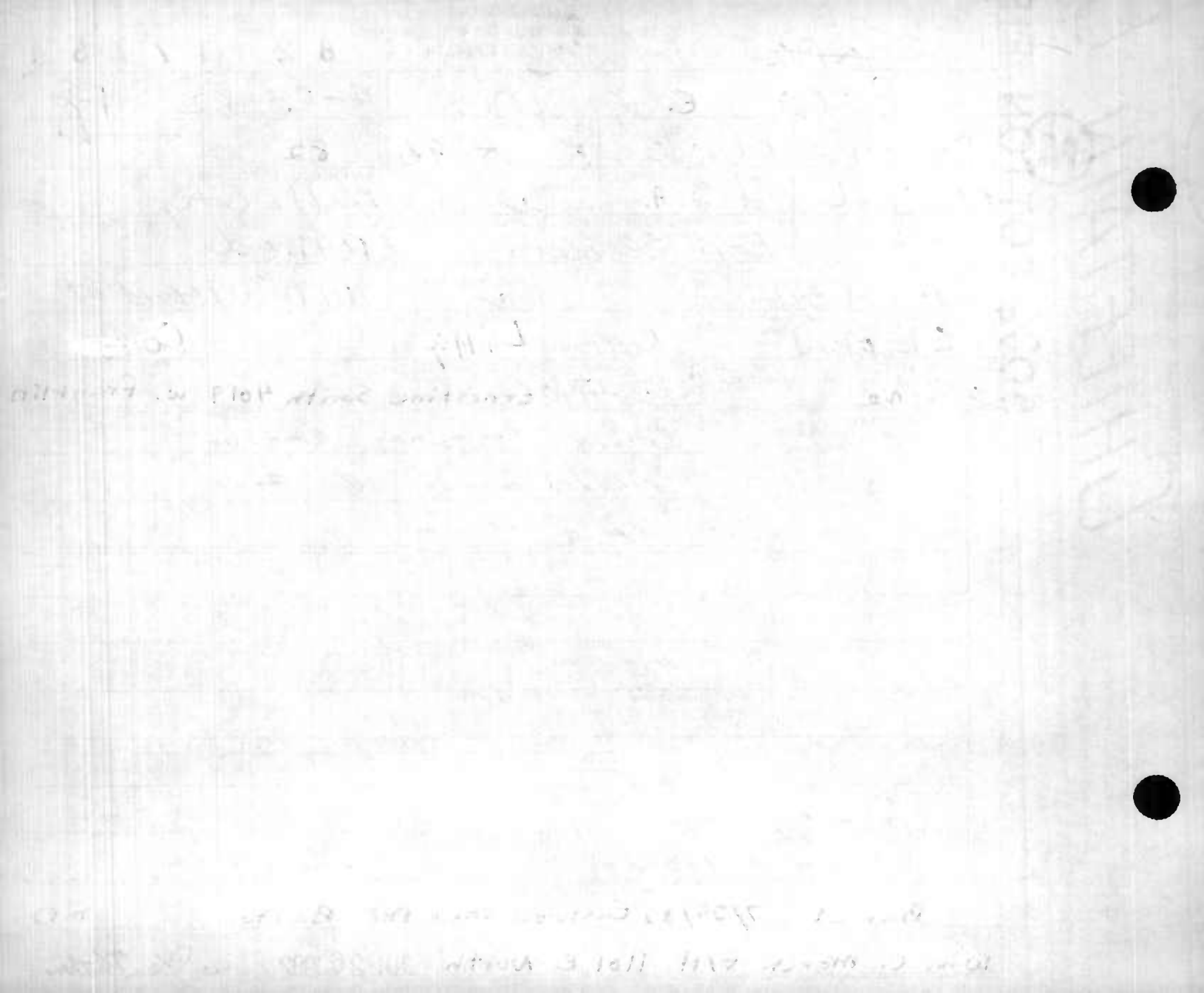
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(M)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR <i>Edna</i> | | REG. NO. <i>82 17764</i> | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) <i>Edna E. Jones</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>7-23-82</i> 2b. HOUR <i>12</i> M | | | | | | | |
| 3. SEX <i>Female</i> | 4 RACE <i>Black</i> | 5. DATE OF BIRTH MONTH DAY YRS. <i>5 15 00</i> | 6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS. | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i> | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Balt.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i> | | | | | | |
| 13a. STATE <i>Balt.</i> | 13b. COUNTY <i>Balt.</i> | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Cleveland Ross</i> | 15. MOTHER'S MAIDEN NAME MIDDLE LAST <i>Lilly Ross</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>unk-No</i> | 16b. SOCIAL SECURITY NO. <i>217-20-9746</i> | 17. INFORMANT ADDRESS <i>Ernestine Smith 4019 W. Franklin</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia Embolism</i> 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pulmonary embolism @ Transit</i> (c) <i>CA 1 metast</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/24</i> , 19 <i>82</i> to <i>7/23</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>7/23</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Francis E. March</i> | DEGREE | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED <i>7/23/82</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Francis E. March</i> | 22e. ADDRESS <i>1101 E. North</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | 23b. DATE <i>7/29/82</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Eastview Mem Pr.</i> | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. MD</i> | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Wm. C. March F/H</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 26 1982</i> 25b. REGISTRAR'S SIGNATURE <i>Francis E. March</i> | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 6 5
REG. NO.

| | | | | | | | | | |
|---|---|---|--------|--|-------------------|--|------------------|------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| EMMA JONES | | | | | 7 | 22 | 82 | | 9:45 ^M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| FEMALE | NEGRO | MONTH 5 DAY 13 YEAR 1917 | | 65 | MONTHS | | DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Virginia | USA | | | BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | UNION MEMORIAL HOSPITAL | | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | | | |
| Maryland | | Baltimore | | 1300 E. Lanvale St. Apt. 312 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | | | | | |
| Richard Murray | | Roberta Yancey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 219-26-5959 | | George L. Jones 3947 Bayville Rd. Chase, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute MI & Pulmonary Edema</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Metastatic Cancer - Colon</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 6/25/82 | | Metastatic Ca | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/82</u> , 19 <u>82</u> , to <u>7/22</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE <u>David C. Allen</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>7/22/82</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| DAVID C. ALLEN, M.D. | | 201 E. UNIVERSITY PARKWAY | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 6/26/82 | | Baltimore Cemetery | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| WM. C. MARCH F/H 1101 E. NORTH AVENUE | | JUL 26 1982 | | <u>James J. Wither</u> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17766 | |
|--|---------|------------------------------|---|--|-------------------|---|---|---------------------|---|----------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 20. DATE KNOWN OF DEATH | | | 26. HOUR | | |
| Howard M. Jones | | | | | | DATE KNOWN OF DEATH ESTIMATED X 7 7 19 82 | | | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 21. DATE PRONOUNCED DEAD | | | 24. HOUR | | |
| MALE | BLACK | 10 27 94 87 | YRS. | MONTHS | DAYS | 7 8 19 82 | | | 7:14 PM | | |
| 76. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 76. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | PM | | |
| Md | | USA | | | | Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 126. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | | | 1005 W. 42nd Street | | | Chauffeur | | | Rt. Family | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Md | | | BALTO | | BALTO | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1005 W 42nd St | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| NICHOLAS T. JONES | | | ANNIE L BERRY | | | YES | | | 219-01-9296 | | |
| 17. INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | 17. INFORMANT | | | ADDRESS | | |
| Mrs Dorothy Lee | | | 4292 | | | Mrs Dorothy Lee | | | 13722 JARRETTSVILLE Pk | | |
| | | | PART 1 DEATH WAS CAUSED BY: | | | | | | PHOENIX BALTO, CO | | |
| | | | IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (b) | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | | | | |
| Hormez R. Guard, M.D. | | | Assistant | | | 7/9/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 111 Penn Street, Balto., MD 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 7/12/82 | | | Arbutus Mem. Pk. | | | BALTO, MD | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Chatman F/H | | | 1701 McCulloch St | | | JUL 12 1982 | | | Hormez R. Guard | | |

CONFIDENTIAL

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17767 |
|--|-------------------------|--|---|--|--|---|--|---|--|-----------------------|
| 1- FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) John Jones | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 18 19 82 | | 2b. HOUR M | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 6 9 07 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 18 19 82 | | 2d. HOUR 6:17A |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1102 Druid Hill Avenue/Rear | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | 13b. COUNTY | | 13c. CITY OR TOWN Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1102 Druid Hill Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unkn. | | 16b. SOCIAL SECURITY NO. 223-22-5972 | | 17. INFORMANT Mrs. Julia Hunter | | ADDRESS 1312 N. Fulton Ave. Balto., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9870 IMMEDIATE CAUSE (a) multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:15xx 7/ 18/ 82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell from 3rd floor to ground | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) balcomy | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1102 Druid Hill Avenue, Baltimore, MD | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Multiple Injuries <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE H. R. Guard | | TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 7/18/82 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | ADDRESS 111 Penn Street, Balto. MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 3 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. Hunter</i> | | | | |

BP

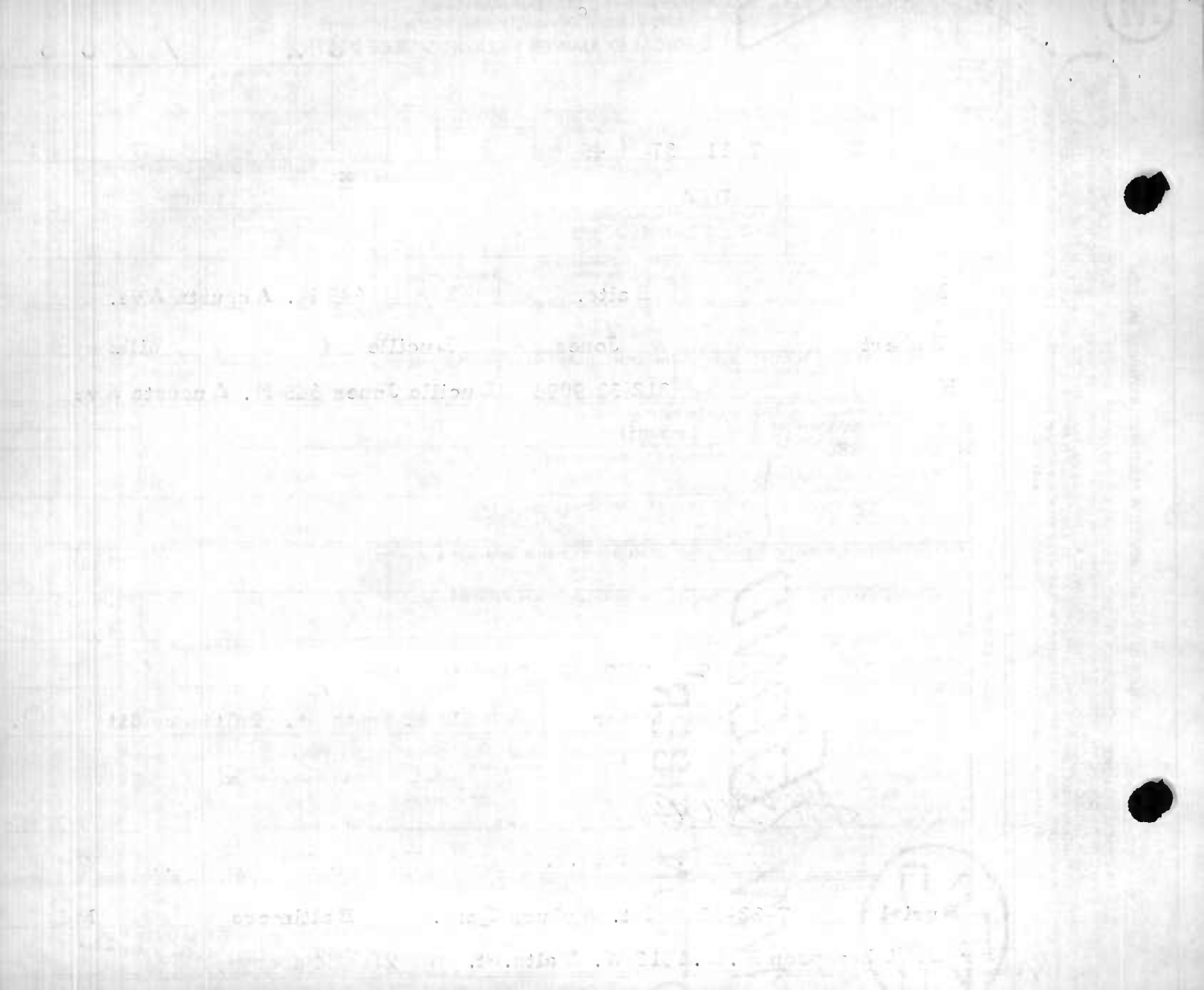


UNION

4387-1001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR 1- STATE REGISTRAR | | | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | REG. NO. 7 7 6 8 | | | |
|--|--|------------------|--|---|--|--|--|--|--|--|--|---|--|--|--|------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) LOUISE | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 7 17 19 82 | | | | | | 2b. HOUR M | | | | | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 7 11 37 | | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 45 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 17 19 82 | | 7d. HOUR 4:A M | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harbor / Rear of World Trade Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE Md | | | | 13b. COUNTY Balto. | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS 645 N. Augusta Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert Jones | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Wilke s | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 212 32 9094 | | | | 17. INFORMANT ADDRESS Lucille Jones 645 N. Augusta Ave | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9840 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:55 AM 7/17/1982 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found in water | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Inner harbor | | | | 21f. LOCATION (rear) CITY OR TOWN COUNTY STATE 400 Blk E. Pratt St. Baltimore City Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE H.R. Guard | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 7/17/82 | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | | ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson F.H. 1913 W. Balto. St. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | 25b. REGISTRAR'S SIGNATURE Charles Jean Nathan | | | | | | | | | | | |



Items #18a-22a Film G570 8/30/82 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
 1- STATE REGISTRAR

REG. NO. 7 7 6 9

| | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|---|--|---------|--|-------|--|------|--|---------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 20. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 76 HOUR | |
| Pearl | | Gloria | | Jones | | | | 21. DATE PRONOUNCED DEAD | | 7 | | 17 | | 1982 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS (LAST BIRTHDAY) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7. DATE | | MONTH | | DAY | | YEAR | |
| Female | Black | 7 16 39 | | 43 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | 7 | | 17 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| MD | | USA | | | | Baltimore City | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Baltimore | | 2202 Druid Hill Avenue | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| MD | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 2202 Druid Hill Avenue | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Joseph | | Katie | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | 217-40-2059 | | James Barksdale | | 2134 Bolton St. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 5718 | | Fatty change of liver | | | | | | | | | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | Diabetes mellitus | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | M.D. Assistant | | MEDICAL EXAMINER | | DATE SIGNED | | 7/17/82 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | Hormez R. Guard, M.D. | | ADDRESS | | 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| Burial | | 7/22/82 | | Mt. Zion Cem. | | Baltimore | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Wm. C. March F/H | | 1101 E. North Ave. | | JUL 21 1982 | | Frances Jan Nathan | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
JUL 10 1967

UNITED STATES
NAVY

NAVY
NO 10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 7 0 REG. NO. | |
|---|--|--|--|---|--|---|--|---|-----------------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Thomas Jones | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 7 82 | | | 2b. HOUR 5:25 P M | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 3 5 37 | | 6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS | | 7. IF UNDER 1 YEAR MONTHS DAYS 4 2 | | 8. IF UNDER 1 HRS HOURS MIN. | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN-SUCH FACILITY, GIVE STREET ADDRESS) Sina. Hospital of Balt. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Horse-boy carner | | 12b. KIND OF BUSINESS OR INDUSTRY Race track | | | |
| 13a. STATE MD 13b. CITY OR TOWN Jefferson 13c. CITY OR TOWN Charlestown | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Belvedere and Greenspring Hvr | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Henry Jones | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy mae Jones | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 573-48-0969 | | 17. INFORMANT ADDRESS Dorothy J. Jones 944 Montepier St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pleural effusion | | | | | | | | | | 6 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Adeno ca of Lung | | | | | | | | | | 6 week | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1 , 19 82 , to July , 19 7 , that (I) (we) lost saw the deceased alive on 7/7 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward D Zimmerman | | | | DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward D. Zimmerman | | | | 22e. ADDRESS 847 Sina. Hospital of Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/12/82 | | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H, Inc. 1101 E. North Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 | | 25b. REGISTRAR'S SIGNATURE Charles Jan Nathan | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 7 1 REG. NO. | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) <u>William M. Jones Jr</u> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>7 21 82</u> | | 2b. HOUR <u>435 PM</u> | |
| 3 SEX <u>M</u> | | 4 RACE <u>B</u> | | 5 DATE OF BIRTH MONTH DAY YEAR <u>9-17-32</u> | | 6 AGE (IN YEARS LAST BIRTHDAY) <u>49</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.C.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD. | | | |
| 10 CITY OR TOWN OF DEATH <u>Balto</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Baltimore City Hosp</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u> | | 13b. COUNTY <u>BALTO</u> | | 13c. CITY OR TOWN <u>BALTO</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>2205 LYN BROOK AVE</u> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>W. M. Jones Sr.</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Susie E. Williams</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. <u>243-52-571</u> | | 17 INFORMANT <u>Melvinda Jones</u> | | ADDRESS <u>2628 Preston</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4310</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>probable hypertensive intracranial hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>35 minute</u> <u>3 days</u> <u>3 days</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-18-82</u> , 19____, to <u>7-21-82</u> , 19____, that (I) (we) lost saw the deceased alive on <u>7-21-82</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>William Russell</u> | | | | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>7/22/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William Russell</u> | | | | 22e. ADDRESS <u>1739 Eutan Pl Balt MD 21217</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>7/28/82</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Church Cem</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balt MD 21217</u> | | | |
| 24. FUNERAL DIRECTOR NAME <u>VERNON R. Binkley</u> | | | | ADDRESS <u>1345 N. Calhoun St</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JUL 26 1982</u> | | REGISTRAR'S SIGNATURE <u>James J. [Signature]</u> | |



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--------------------------------|--|-----------------------------------|---------------------------------|--|--|
| 3 - FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST Willie | MIDDLE C. | LAST Jones | 2a. DATE OF DEATH | MONTH 7 | DAY 8 | YEAR 82 | 2b. HOUR 11 ³⁰ AM | |
| 3 SEX MALE | 4 RACE NEGROID | 5. DATE OF BIRTH | | MONTH APR. | DAY 29 | YEAR 1909 | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS YRS | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C. USA | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | | | MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY BALTO | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3106 Walbrook Ave. | | | | | | |
| 14. FATHER'S NAME FIRST KELLEY | | MIDDLE JONES | | LAST JONES | | 15. MOTHER'S MAIDEN NAME FIRST Maryetta | | MIDDLE ? | | LAST ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATE) 216-10-3736 | | 17. INFORMANT Margaretta B. Jones | | ADDRESS 3106 Walbrook Ave. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest (shock)</u> 1532 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EMBOLISM</u> (c) <u>DEEP VEIN THROMBOSIS RT LEG.</u> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>6 days</u> <u>8 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SPCARCINOMA LT COLON WITH PERFORATED DIVERTICULITIS</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 6.22.82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CLOSURE COLOSTOMY | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> 19 <u>82</u> , to <u>7-8</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7-7</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Ernesto Molino | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-8-82 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERNESTO MOLINO | | | | 22e. ADDRESS 2918 MONTCLAIR DR. ELICOTT CITY. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY Md. Natl. Mem. Pk. | | 23d. LOCATION CITY OR TOWN Laurel | | COUNTY MD. | | STATE | | |
| 24. FUNERAL DIRECTOR NAME Calvin B. Scruggs | | | | ADDRESS Preston St. | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. [Signature] | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 | | 1 7 7 7 3 | |
|--|--|--|--|---|--|--|--|--|--|---|--|-----------|--|
| FOR 1 - STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT THOMAS JORDON | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 6, 1982 | | | | 2b. HOUR P 3:00 M | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10/13/1937 | | 6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4306 MIAMI PLACE | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY GENERAL CONTRACTING | | | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY ----- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4306 MIAMI PLACE 21207 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARMELIA JORDON | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED ROGERS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 219-32-1670 | | 17. INFORMANT ADDRESS DOLLIE J. JORDON (WIFE) SAME AS 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CANCER OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JUNE 3 19 1982 , to JULY 6 19 82 , that (I) (we) last saw the deceased alive on JULY 6 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Lydia M. Jumamoy, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/7/1982 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LYDIA M. JUMAMOY, M.D. | | | | | | 22e. ADDRESS 1576 MERRITT BLVD. DUNDALK, MD. 21222 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 7/7/1982 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY, INC. ADDRESS: BALTO., MD. 21222 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 25b. REGISTRAR'S SIGNATURE Frances Van Notten | | | | | | | |

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DIRECTOR OF THE
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TO THE DIRECTOR OF THE BUREAU OF THE CUSTOMS AND EXCISE

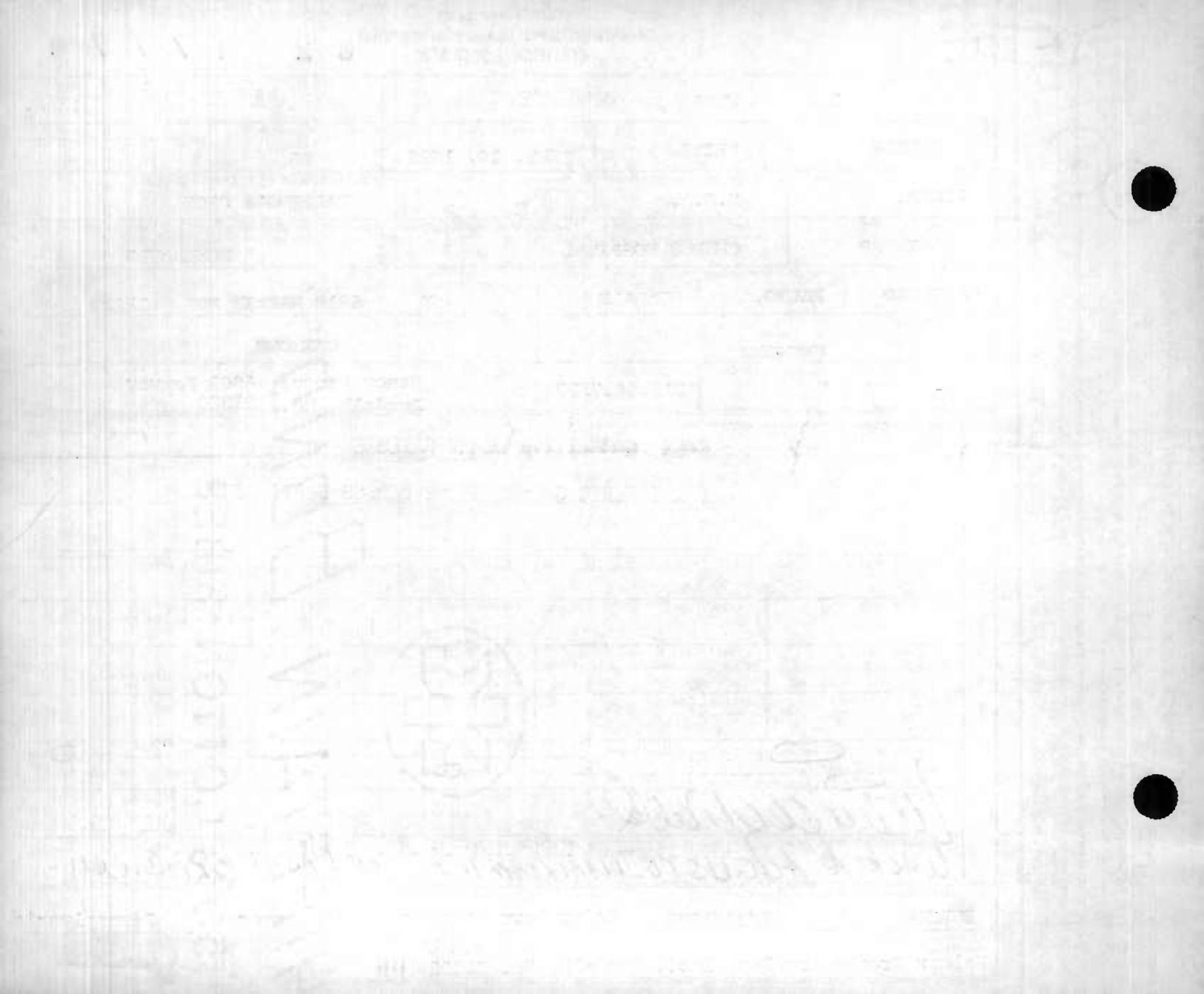
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 7 4 REG. NO. | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST SUE ETTA JORGENSEN | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 25, 1982 | | 2b. HOUR 11:25A | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 24, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (# NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN DUNDALK | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 6818 MARTIN AVE, 21222 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215.46.7577 | | 17. INFORMANT ADDRESS Nancy Fanguie 6903 Fenway Dundalk, Md. 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 4280 IMMEDIATE CAUSE (a) ROMS CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK VERSUS SEPTIC SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from JULY 19 19 82, to JULY 25 19 82, that (I) (we) last saw the deceased alive on JULY 25 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Augusto Impaciatelli</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED JULY 25, 1982 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALKER AUGUSTO IMPACIATELLI | | 22e. ADDRESS 100 NORTH BROADWAY | | 22f. NAME OF HOSPITAL OR OTHER INSTITUTION CHURCH HOSPITAL CORPORATION | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7/28/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lancaster Pennsylvania | | | | | |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc., Dundalk, Md, 21222 | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i> | | | | | |



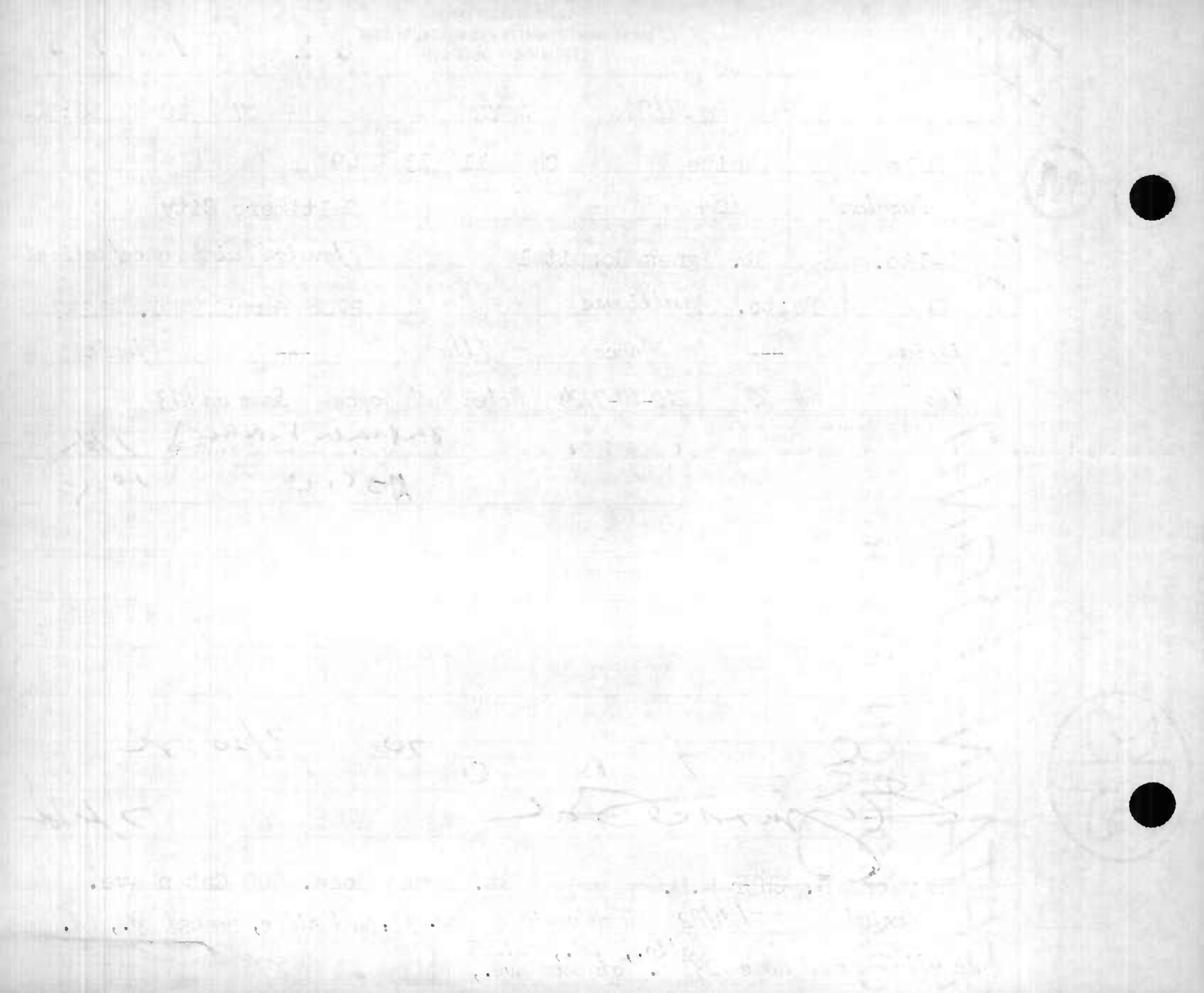
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| FOR 1. STATE REGISTRAR | | 8 2 1 7 7 7 5 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN W ILLIAM JOYCE | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 20 82 | | 2b. HOUR 10:50 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 04 11 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elevator Maintenance/Retired | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2706 Yarnall Rd. 21227 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William --- Joyce | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella --- Clendry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-7724 | | 17. INFORMANT Helen Ruth Joyce | | ADDRESS Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 min | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 19 20 to 2/20 19 82, that (I) (we) lost saw the deceased alive on 2 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Raymond B. Bahr, M.D. | | | | 22c. DATE SIGNED 2/20 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond B. Bahr, M.D. | | | | 22e. ADDRESS St. Agnes Hosp. 900 Caton Ave. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/24/82 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME McClully Funeral Home | | | | 24b. ADDRESS Balto., Md., 21225 237 E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR JUN 22 1987 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 20. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | 2c. MIN. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | JULY 21/1982 | | 11:25 | | A.M. | |
| 2. SEX | | 3. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| FEMALE | | BLACK | | 12/25/21 | | 60 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. BALTIMORE CITY MD. | |
| S.C. | | U.S.A. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTIMORE | | BON SECOURS HOSPITAL | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | |
| MARYLAND | | BALTIMORE CITY | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1616 POPLAR GROVE ST. | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| John Manning | | Mayreza McClain | | no | | 213-26-0854 | | Wm. Jukes 616 Poplar Grove St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. IMMEDIATE CAUSE (a) | | 20. DUE TO, OR AS A CONSEQUENCE OF | | 21. DUE TO, OR AS A CONSEQUENCE OF | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 2500 | | MASSIVE ACUTE PULMONARY EMBOLISM | | DIABETES MELLITUS (ADULT TYPE) | | STATUS POST - ABOVE KNEE AMPUTATION | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | LEG 2° GANGRENE | | ARTERIOSCLEROSIS CARDIOVASCULAR | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 20, 1982, to July 21, 1982, that (I) (we) last saw the deceased alive on July 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | |
| D. GONZALES | | MD | | 7/21/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE SIGNED BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | |
| D. GONZALES | | 2011 W. PAYETTE BALTIMORE MD. 21223 | | JUL 23 1982 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Burial | | 7/26/82 | | Arbutus Men. Park | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 24c. DATE SIGNED BY REGISTRAR | | 24d. REGISTRAR'S SIGNATURE | | | |
| R. W. WRIGHT | | 2700 Edmonds Ave | | JUL 23 1982 | | | | | |

RECEIVED
JAN 11 1912

2012 COLLECTION

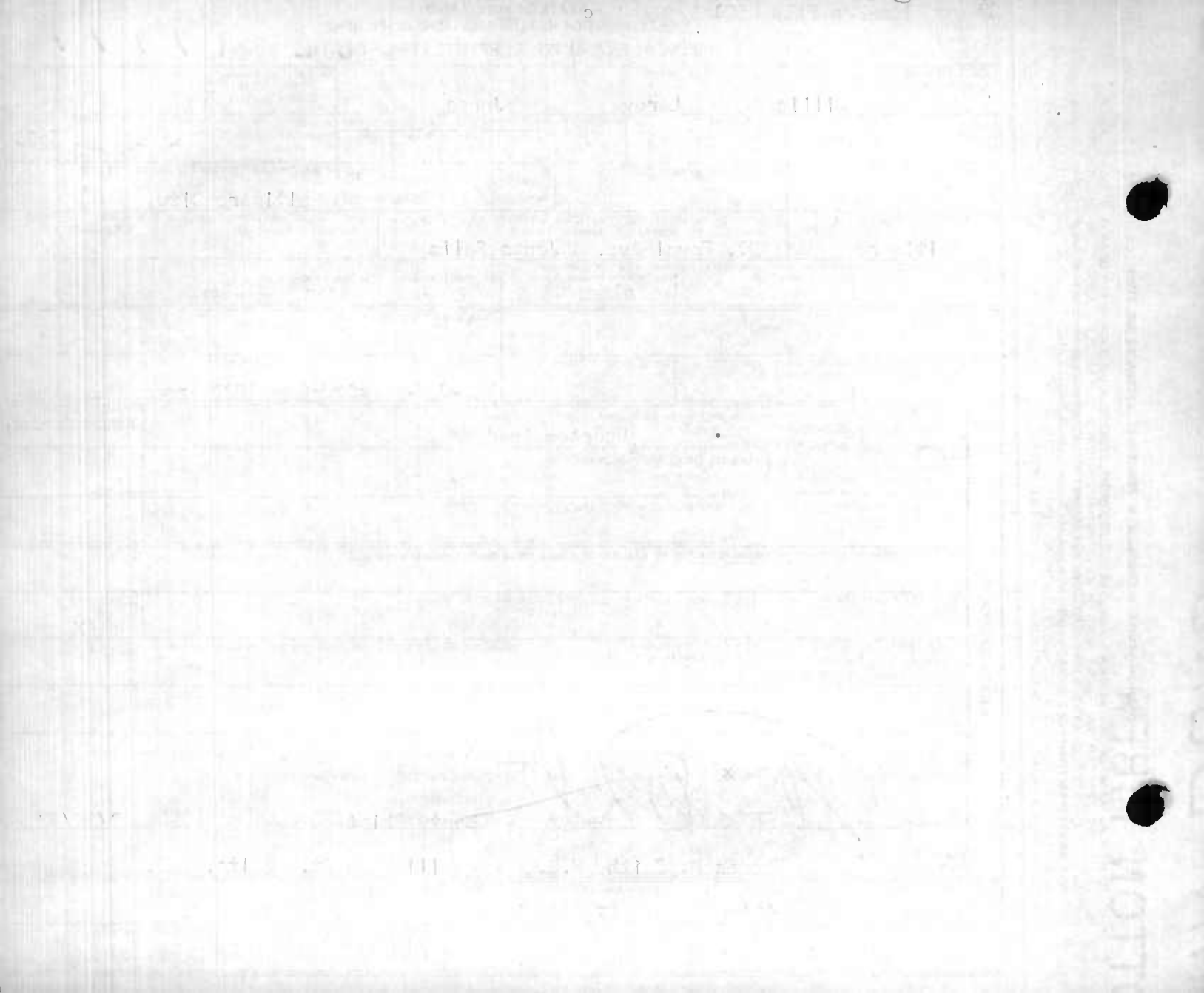


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G571 9/30/82 r6 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17777

| | | | | | | | |
|--|------------------|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Leroy Junes | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 19 | | | 2b. HOUR M | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 7 31 34 | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD 7 28 1982 | 2d. HOUR 5:35 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mt. Royal Ave. & Jones Falls | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE Md. | | 13b. COUNTY BALTO. | 13c. CITY OR TOWN Balto. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 1533 Ensor St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unkn | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Junes | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Ethel Lee McKnight 1533 Ensor St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7999 IMMEDIATE CAUSE (a) Undetermined Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 7/29/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 111 Penn St. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8/4/82 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Landsdown, Md. | |
| 24. FUNERAL DIRECTOR NAME Wm C March F/H | | | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR AUG 06 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE John J. Connel | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in block, it must be retained for use as the burial permit. Then please remove carbon papers. Pages 5 and 7 should be filed in the 24-hour file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 7 8 REG. NO. | | | | |
|---|--|---|--|---|--|--|--|---|--|--|---|---------------------------|----------|--|
| 1. FOR STATE REGISTRAR | | | | | I. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | |
| MATTHEWS KAISER | | | | | JULY 2 1982 | | | | | 1:02pm | | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 22 1982 | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 10 | | IF UNDER 1 YEAR MONTHS DAYS 10 | | IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE MARYLAND | | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN PERRY HALL | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 9 AVONMORE COURT | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK KAISER | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MICHELE KOPCHICK | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT FRANK KAISER | | | | | ADDRESS SAME 13E ABOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 7718 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypotension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>probable sepsis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours days | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> , 19 <u>82</u> , to <u>JULY 2</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JULY 2</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Jeffrey H. Silber, MD | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED 7/2/82 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY H. SILBER | | | | | 22e. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE JULY 6 1982 | | 23c. NAME OF CEMETERY OR CREMATORY S.S. PETER + PAUL | | | 23d. LOCATION CITY OR TOWN WEST MIFFLIN ALLENTOWN PA. | | | | | | |
| 24. FUNERAL DIRECTOR NAME E.F. LASSAHN F.H. | | | | | ADDRESS 7401 BEL AIR R.D. | | 25. DATE REC'D. BY REGISTRAR JUL 12 1982 | | SIGNATURE | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8217779 | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) AVRAM KALDERON | | 2a. DATE OF DEATH MONTH DAY YEAR 07-06-82 2b. HOUR 8:52 M | |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 3 21 1904 | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) YUGOSLAVIA | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTO. CITY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVIN DALE | 12a. USUAL RESIDENCE (TYPE OF WORK AND NATURE OF WORKING LIFE) RETAIL | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND | 13b. COUNTY BALTO. | 13c. CITY OR TOWN BALTO. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 6638 EBERLE DR. Apt. 302 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST DAVID KALDERON | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORA BURACH | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | |
| 16b. SOCIAL SECURITY 217-26-248 | | 17. INFORMANT MRS. BERTA KALDERON | | ADDRESS 6638 EBERLE DR., APT. 302 #21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1850 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF CACHEXIA OF MALIGNANCY DUE TO, OR AS A CONSEQUENCE OF CARCINOMA OF THE PROSTATE (c) PARAPLEGIA 20 SPINAL METASTASES | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 02/17 1981 to 07-06 1982 , that (I) (we) lost saw the deceased alive on 07-06 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Bo TAN-WIN | | DEGREE | | 22c. DATE SIGNED 7-6-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bo TAN-WIN | | 22e. ADDRESS LEVINDALE GERIATRIC CTR 21215 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JULY 7, 1982 | 23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESED | 23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD | 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. | |
| 24. FUNERAL DIRECTOR NAME 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR JUL 8 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 82 17780 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | |
| I. DECEASED NAME FIRST MIDDLE LAST MRS LILIAN M KANE (Kane) | | | | 7/17/82 | | | |
| 3. SEX R | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 10-1-05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH CITY | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOUR HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | | | 13b. CITY OR TOWN BALTO | | 13c. STREET ADDRESS Frederick Ave 21248 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William J. Riggs | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Krauss | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) - | | | | 16b. SOCIAL SECURITY NO. 215076765 | | 17. INFORMANT ADDRESS 5524 Frederick Ave Balt 21248 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructing Rt Colon CA. with 1539 } DUE TO, OR AS A CONSEQUENCE OF (b) extensive invasion of abdominal wall & severe bleeding for CA. (c) } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Anemia CHF. | | | | | | | |
| 19a. DATE OF OPERATION 5/24/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA Colon Bleeding | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/17/82, 1982, to 7/17/82, 1982, that (I) (we) last saw the deceased alive on 5/17/82, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE A. W. Ananach | | | | DEGREE | | 22c. DATE SIGNED 7/17/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ananach A. | | | | 22e. ADDRESS BON SECOUR HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 20, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | |
| 24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md. 21229 | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 19 1982 Anne J. [Signature] | | | |

(over)

James Brown

William J. Brown



July 20, 1962

Post

2. Brown Brown 2512 Webster Ave. St. Louis, Mo.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS REQUIRED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7781 | |
|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PAUL KANE | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-11-82 | | 2b. HOUR 11:20 AM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 8 19 19 62 YRS. | | 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 62 | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-11-82 | | 7d. HOUR 11:20 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) - Disabled | | | |
| 13a. STATE MD | | | | 13b. COUNTY - | | | | 13c. CITY OR TOWN Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Leo Kane | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhea Karrer | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. 218-01-1927 | | | | 17. INFORMANT Mr. Joseph Lito | | | | 17b. ADDRESS 4110 Milford Mill Rd., Baltimore, MD 21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? (BODY ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described in this certificate. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | DATE SIGNED 7-13-82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.d. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/15/82 | | | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | | |
| 23d. LOCATION CITY OR TOWN Baltimore City | | | | COUNTY MD | | | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. | | | | | | 25. DATE REC'D BY REGISTRAR JUL 15 1982 | | | | | |
| ADDRESS 8728 Liberty Rd., Randallstown, MD 21133 | | | | | | 26. REGISTRAR'S SIGNATURE Frances Van Natten | | | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 7 8 2

| | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. DATE OF DEATH | | | 2c. DATE PRONOUNCED DEAD | | | 2d. DATE OF DEATH | | |
| FIRST Abdul | | | MIDDLE Karim | | | LAST Kanu | | | MONTH 7 | | | DAY 17 | | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MONTH March | | | YEAR 1948 | | | 6. AGE (IN YEARS) LAST BIRTHDAY 34 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sierra Leone | | | 7b. CITIZEN OF WHAT COUNTRY? Sierra Leone | | | 8. MARRIED WIDOWED | | | NEVER MARRIED | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed | | | 12b. KIND OF BUSINESS Life Ins., Co. | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Prince Georges | | | 13c. CITY OR TOWN Greenbelt | | | 13d. INSIDE CITY LIMITS? YES | | | 13e. STREET ADDRESS 8433 Greenbelt Road, | | |
| 14. FATHER'S NAME FIRST Santigie | | | MIDDLE | | | LAST Kanu | | | 15. MOTHER'S MAIDEN NAME FIRST Iye | | | MIDDLE Kanu | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no | | | (IF YES, GIVE WAR OR DATES) | | | 16b. SOCIAL SECURITY NO. 578-74-5225 | | | 17. INFORMANT Amie Kanu-wife- | | | ADDRESS (same as 13e) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Cranio-cerebral injury DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:50A. 7/17 1982 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway | | | 21f. LOCATION STREET Md Rt #38 | | | CITY OR TOWN Brightview Rd. | | | COUNTY AA Co., MD | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE H R Guard | | | TITLE (SPECIFY) M.D. Assistant | | | | | | DATE SIGNED 7/17/82 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | | ADDRESS 111 Penn Street, Balto. MD | | | | | | 21201 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal | | | 23b. DATE July 23, 1982 | | | 23c. NAME OF CEMETERY OR CREMATORY Magbele Cemetery | | | 23d. LOCATION CITY OR TOWN Freetown | | | | | |
| 24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home | | | ADDRESS 11800 N.H. Avenue, Silver Spring, Md. | | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | REGISTRAR'S SIGNATURE [Signature] | | | | | |
| 25b. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |



Mr. Frank Smith, 1234 Main St.,
Springfield, Mo.
Dear Mr. Smith:
I am writing to you regarding the matter
of the missing funds from the
Springfield Trust Company.
The amount of \$10,000.00 was
missing on March 15, 1934.
I am sure you will understand the
importance of this matter.
Very truly yours,
J. Edgar Hoover
Director

Enclosed for you are two copies of
the report of the investigation.
Very truly yours,
J. Edgar Hoover
Director

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|---|--|--------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| REG. NO. 82 17783 | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Carl J Kapraun | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 25 82 | | | 2b. HOUR 10 P M | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 2 2 16 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3409 Pleasant Place | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steamfitter | | 12b. KIND OF BUSINESS OR INDUSTRY Constr. Loc 438 | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank J. Kapraun | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly M. Sullivan | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO 213-05-0401 | | 17. INFORMANT ADDRESS Evelyn Miller Kapraun 3409 Pleasant Place | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 1539 IMMEDIATE CAUSE (a) <u>coronoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION 3/6/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronoma | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) — | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12/82 to 7/25/82, that (I) (we) lost saw the deceased alive on 7/12/82 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Wm F. Renner | | 22c. DATE SIGNED 7/25/82 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm F. Renner | | | | |
| 22e. ADDRESS 3222 St. Paul St | | 22f. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | | 22g. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | 22h. DATE REC'D. BY REGISTRAR JUL 28 1982 | | | | |
| 22i. REGISTRAR'S SIGNATURE Alan Seitz | | 22j. REGISTRAR'S NAME A. Alan Seitz | | | | | | | | |
| 22k. ADDRESS 3818 Roland Ave. | | 22l. DATE REC'D. BY REGISTRAR JUL 28 1982 | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8217784 | | | | |
|--|--|---|---|---|--|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN V. KARWACKI | | | | 7-18-1982 | | | | M |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 3 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 79 | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY | | MD. |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2446 FLEET ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST LOUIS CHYLIANSKI | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DAMICZ | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO 214 402515 | | 17. INFORMANT ADDRESS EUGENE KARWACKI | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart failure. 4029 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis. | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-9-81 19, to 6-26 19 82 , that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE M. N. Khan. | | | | DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/20/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. N. KHAN | | | | 22e. ADDRESS 2711 Eastern Ave. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 7-21-1982 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI | | | | ADDRESS 2525 FLEET ST. | | 25. DATE REC'D. BY REGISTRAR JUL 22 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 82 17785

| | | | | | | | |
|--|---|--|--------------------------------------|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Flora (NMN) Kasper | | July 26, 1982 | | 3:02 AM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | White | Feb. 5, 1901 | 81 YRS | | | | |
| 7a. BIRTHPLACE | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Alabama | U.S.A. | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore City, MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Baltimore | DEATON Medical Center | | Homemaker | | Own Home | | |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | | | | |
| Maryland | | A.A. | 141 Olen Drive | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| James Henson | | Emmer King | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) ADDRESS | | Same as # 13 | | |
| No | | N/A | Mrs. Louise G. Donat | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| 1930 IMMEDIATE CAUSE (a) hemorrhage | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | 4 months |
| (b) metastatic tumor in neck | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | 16 yrs |
| (c) malignant cancer of the thyroid | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 3/82 | | spread of tumor in neck | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | |
| (IF EITHER, NOTIFY MEDICAL EXAMINER) | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/18, 19 82, to 7/26, 19 82, that (I) (we) lost saw the deceased alive on 7/26, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| DE KING | | | | J.L. Deaton | | 7/26/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | |
| Burial | | 30 July 82 | Gethsemane Cem. | | Detroit, Michigan | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Singleton Funeral Home | | JUL 27 1982 | | Frances Santhorn | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 7 8 6 REG. NO. | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BENNY L. KATZEN | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1982 | | | | 2b. HOUR 7 P. M. | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR AUG. 16, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3316 CLARKS LA., APT. B | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AGENT | | 12b. KIND OF BUSINESS OR INDUSTRY INSURANCE | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. B 3316 CLARKS LA. | | #21215 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL KATZEN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 215-01-0353A | | 17. INFORMANT MRS. SARAH KATZEN | | APT. B | | BALTO., MD 21215 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4439 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Personal vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Per. blood neuropathy | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (1) <u>the</u> hospital attended the deceased from <u>July 23, 1982</u> to <u>July 23, 1982</u> , that (1) <u>the</u> last saw the deceased alive on <u>July 23, 1982</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.) | | | | | | | | | | | |
| 22b. SIGNATURE Seymour Rubinfeld | | | | DEGREE PHYSICIAN | | | | 22c. DATE SIGNED 7/24/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEYMOUR RUBIN, MD | | | | 22e. ADDRESS 7111 PARK HTS. AVE. BALTO., MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. | | | | ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | 25a. DATE REC'D BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | |

1. The first part of the report is a general description of the project and its objectives. This section is intended to provide a clear understanding of the scope and purpose of the study.

2. The second part of the report is a detailed description of the methodology used in the study. This section is intended to provide a clear understanding of the methods and procedures used to collect and analyze the data.

3. The third part of the report is a description of the results of the study. This section is intended to provide a clear understanding of the findings of the study and to discuss the implications of these findings.

4. The fourth part of the report is a conclusion and a discussion of the study. This section is intended to provide a clear understanding of the overall findings of the study and to discuss the implications of these findings.

5. The fifth part of the report is a list of references. This section is intended to provide a clear understanding of the sources of information used in the study.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 11 per phone 7/26/82 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 1 7 7 8 7

| | | | | | | | | | |
|---|---|--|--------|--|--|---|--|---------------------------------|---|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| Goldie | | | | Kavanaugh | 7 | 12 | 82 | | M |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 74 HRS | |
| Female | White | MONTH DAY YEAR 7 19 13 | | 69 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | USA | | | Baltimore City MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | home - 3447 Chestnut Ave. 21211 | | | Retired | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? | | 13c. STREET ADDRESS | | |
| 13a. STATE Maryland | | | | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | |
| 14 FATHER'S NAME | | | | | 15 MOTHER'S MAIDEN NAME | | | | |
| FIRST MIDDLE LAST Marvin Marston | | | | | FIRST MIDDLE LAST Elma Bortle | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | |
| No | | 214-01-3521 | | Audrey Clatterbuck 633 Tumbridge Rd. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 6 mos |
| (b) <u>Brown Metastasis</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | 1 yr. |
| (c) <u>Breast Cancer</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 82</u> to <u>July 19 1982</u> , that (I) (we) last saw the deceased alive on <u>July 19 82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Alan M. Ross</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>7/13/82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | Good Shepherd Cem. | | Ellicott City Howard Co. Md. | | | |
| 24 FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| A. Alan Seitz Funeral Home | | | | 3818 Roland Ave. | | JUL 19 1982 | | <u>James J. [Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 7 8 8 REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|---------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Rosetta Keaton | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 13 82 | | 2b. HOUR 10 40 PM | | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 1 16 23 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA. | | 7b. CITIZEN OF WHAT COUNTRY? United State | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE md. | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1400 E. Madison Apt 1112 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Artis . Kay | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE Beatrice Poole | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 213-16-3463 | | 17. INFORMANT ADDRESS William Keaton 1400 E. Madison St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Refractory Congestive heart failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic renal insufficiency | | | | | | | | | | | |
| 19a. DATE OF OPERATION none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N.A. | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A. | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE NOT AT WORK <input type="checkbox"/> N.A. | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N.A. | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A. | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/14 , 19 82 , to 7/13 , 19 82 , that (I) (we) lost saw the deceased alive on 7/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Dionisio Garcia Jr. M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED 7/14/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DIONISIO GARCIA JR. M.D. | | | | 22e. ADDRESS 4550 BALTIMORE NAT'L. PIKE | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/20/82 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Sp. MD | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave. | | | | 25a. DATE REC'D. BY REGISTRAR JUL 16 1982 | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) AKUTT R. KEEMER | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 20 82 | | 2b. HOUR 10:23 P ^M |
| 3. SEX MALE | 4. RACE BLACK | 5. DATE OF BIRTH MONTH DAY YEAR 06 22 16 | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION |
| 13a. STATE MD | | | 13b. CITY OR TOWN CALVERT HUNTINGTOWN | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Box 261A |
| 14. FATHER'S NAME FIRST MIDDLE LAST RANDY Y. KEEMER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH BROWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO UNKNOWN | | 16b. SOCIAL SECURITY NO. 105-58-600 | 17. INFORMANT ADDRESS Mary Keemer 261-A Wilson Rd., Huntingtown | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1509 IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA & MI DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ESOPHAGEAL CARCINOMA 9 MONTHS | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a MALNUTRITION, CACHEXIA | | | | | |
| 19a. DATE OF OPERATION 10/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGEAL CARCINOMA | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from JULY 20 (yr) 19 82, to JULY 20 (yr) 19 82, that (I) (we) lost saw the deceased alive on JULY 20 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Paul C. Shakin MD | | | | 22c. DATE SIGNED 7/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL C. SHAKIN | | | | 22e. ADDRESS 1018 J. WOODSON ROAD, BALTIMORE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 24-82 | 23c. NAME OF CEMETERY OR CREMATORY Plum Point Chr. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Huntingtown Calvert |
| 24. FUNERAL DIRECTOR NAME Spencer E. Sewell | | | 25. REG'D BY REGISTRAR JUL 26 1982 | | |
| ADDRESS Box 31, Prince Frederick, Md | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



July 2-53 City Center 25th Floor N.Y., N.Y.

RECEIVED
JUL 11 1953
U.S. DEPT. OF JUSTICE

Special E. Sewell Box 7, Prince Frederick, Md.
July 2-53 P.O. Box 7, Prince Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 7 9 0
REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) PINE H. KEHS | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 22 82 | | | 7b. HOUR 1 pm | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 6 22 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Female | | 7b. CITIZEN OF WHAT COUNTRY? White | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 116 West University Pkwy | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard F Anderson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Myers | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 202-03-9152 | | 17. INFORMANT Mr Warren F Kehs | | | ADDRESS Same | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Anterior descending CVD DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/13, 19 81, to 7/22, 19 82, that (I) (we) last saw the deceased alive on 7/22, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harold P. Priene MD | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-22-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/26/82 | | 23c. NAME OF CEMETERY OR CREMATORY Immanuel Luth | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 23 1982 | | 25b. REGISTRAR'S SIGNATURE Anne J. [Signature] | |

10-10-1947

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 9 1 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <i>AGNES</i> | | MIDDLE <i>Rose</i> | | LAST <i>KELLY</i> | | 2a. DATE OF DEATH MONTH DAY YEAR <i>07 23 82</i> | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>Cauc. White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>11 9 03</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS. | | 2b. HOUR <i>11:25AM</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St Agnes Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Catonsville</i> | | 13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/> | | 13e. STREET ADDRESS <i>626 Ingleside Ave</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael J. McGillen</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Roseann Troy</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-12-8027 A</i> | | 17. INFORMANT ADDRESS <i>Mrs Roseann Taylor Same as #13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4310</i> IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>INCREASED INTRACRANIAL PRESSURE.</i> | | | | | | | | <i>2 DAYS</i> | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>MASSIVE INTRACEREBRAL HEMORRHAGE</i> | | | | | | | | <i>2 DAYS</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>07-22</i> , 19 <i>82</i> , to <i>07-23</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>07-23</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Philip M Lam</i> | | DEGREE <i>MD</i> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>07-23-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PHILIP M LAM</i> | | 22e. ADDRESS <i>ST. AGNES HOSPITAL, BALTIMORE, MD.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | 23b. DATE <i>7/26/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Witzke, P.A.</i> | | ADDRESS <i>1630 Edmondson Ave Catonsville, Md. 21228</i> | | 25a. DATE RECEIVED BY REGISTRAR <i>JUL 26 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>James San Martin</i> | | | |

251

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 2 1 7 7 9 2 REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosetta P Kennedy | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 31, 1982 | | 2b. HOUR 11:45pm | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 9 21 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 88 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Balto. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md | | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Balto. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Kennedy | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Kind | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Nora Anderson 7 N. Bernice Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 C-V-A (Cerebrovascular accident) IMMEDIATE CAUSE (a) C-V-A (Cerebrovascular accident) DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive ASD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 82 , to 7/31 , 19 82 , that (I) (we) last saw the deceased alive on 7/31 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Alexander Mellan | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEXANDER MELLAN | | | | 22e. ADDRESS 1900 Sulphur Spring Rd | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8 5 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Remine | |
| 24. FUNERAL DIRECTOR NAME Brown/Thompson F. H. | | | | ADDRESS 1913 W. Balto. St. | | 25a. DATE REC'D. BY REGISTRAR AUG 3 1982 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 7 9 3 REG. NO. | | 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| HELEN S. KERNAN | | 7-19-82 | | 2:35 P.M. | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH 5-30-09 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN CATONSVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 34 DUNMORE RD. | | | |
| 14. FATHER'S NAME HARRY SCHULTZ | | 15. MOTHER'S MAIDEN NAME ALICE REARDON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-07-8882 | | 17. INFORMANT W. STUART KERNAN | | ADDRESS 34 DUNMORE ROAD, 21228 | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 1890 IMMEDIATE CAUSE (a) Cardiac Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Renal Cell carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-12-82, 19 82, to 7-19, 19 82, that (I) (we) lost saw the deceased alive on 7-17, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lawrence M. Sigman | | DEGREE | | 22c. DATE SIGNED 7/19/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. SIGMAN | | 22e. ADDRESS 22 S. Green St. Balt. MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 07-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. | | ADDRESS 21229 4107 WILKENS AVE. | | 25a. DATE REC'D. BY REGISTRAR JUL 20 1982 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Francis Van Natten | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

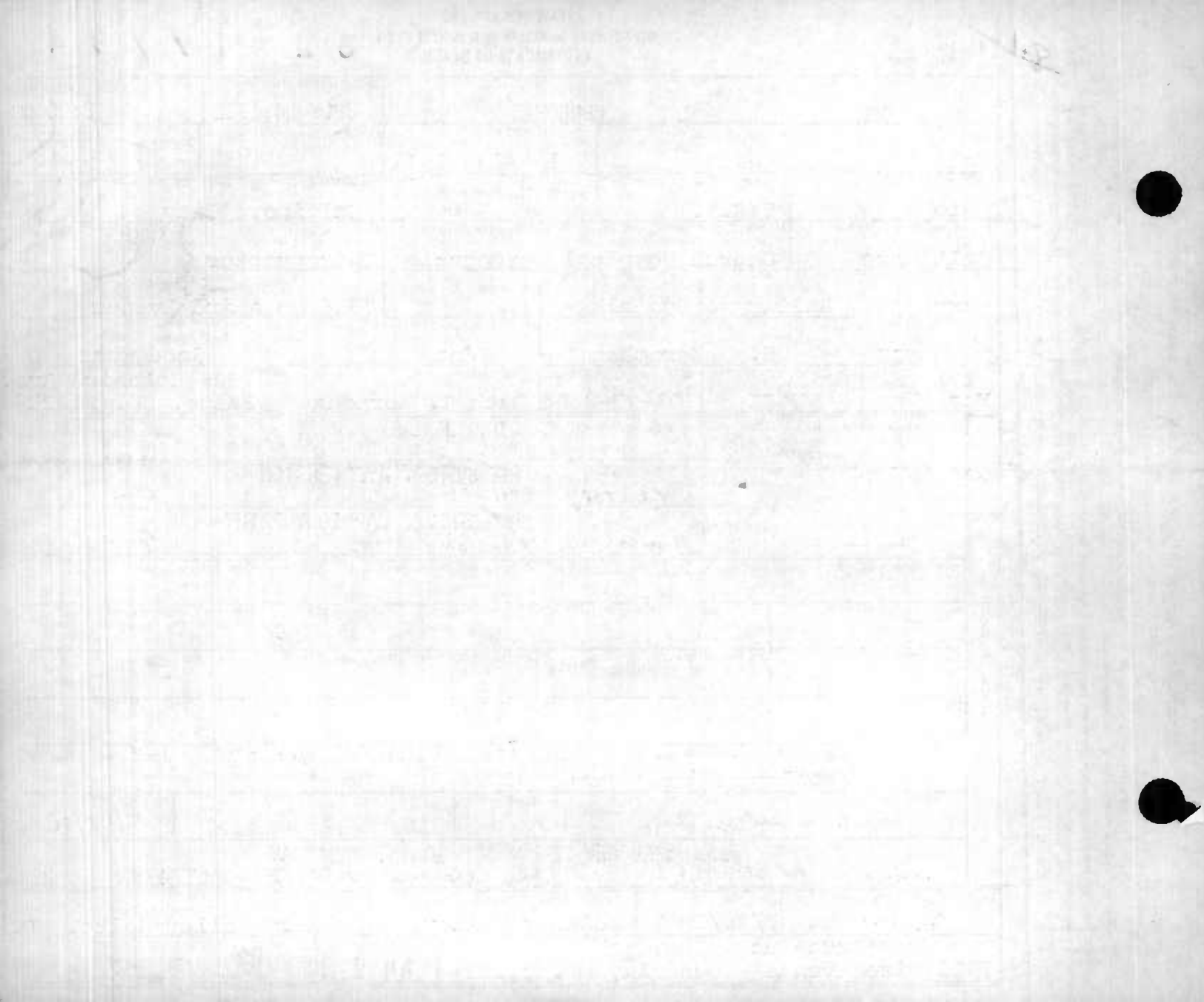
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8+1
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|----------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN L KERNOHAN | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 24, 1982 | | 2b. HOUR 8:20 pm | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 16 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital Corporation | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chiropractor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Dundalk | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7526 Holabird Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Kernohan | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Snodgrass | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II | | 16b. SOCIAL SECURITY NO. 232-07-8096 | | 17. INFORMANT Ruth C. Kernohan | | ADDRESS 7526 Holabird Ave. Balto. MD. 21222 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) REFRACTORY HYPOTENSION DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE CARDIOMYOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last REFRACTORY HYPOTENSION CONGESTIVE CARDIOMYOPATHY APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs 2 hrs again | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/23 7-23 19 82 to 7/24 7-24 19 82 , that (I) (we) lost saw the deceased alive 7-24 7/24 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Mark O. McGaughey M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 7/24/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK O. MCGAUGHEY MD | | | | 22e. ADDRESS 100 N. BROADWAY CHURCH HOSPITAL BALTIMORE, MD; 2123 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment | | 23b. DATE 7/28/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley | | 23d. LOCATION CITY OR TOWN COUNTY STATE Dulaney Valley-Balto. MD. | |
| 24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. | | | | 24. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222 | | 25a. DATE REC'D. BY REGISTRAR JUL 27 1982 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for autopsies.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8 2 1 7 7 9 5 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| FIRST MIDDLE LAST Agnes Anna Ketchum | | | | July 27, 1982 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | MONTH DAY YEAR Sept 9, 1893 | | 88 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | 3516 Woodring Avenue | | Housewife | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST George S Falkenhan | | FIRST MIDDLE LAST Anna Schramm | | 3516 Woodring Avenue | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 215-03-3782D | | Bertha Meksa | | Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL CELL CARCINOMA</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>1981</u> , 19 <u>82</u> , to <u>7/27</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>7/1</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If well) (If did not view the body after death) | | 22b. SIGNATURE <u>George E. Lowe</u> | | DEGREE | | 22c. DATE SIGNED 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| George E. Lowe, M.D. | | 3703 Belair Rd. | | Baltimore, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | 7/30/82 | | Meadowridge | | Dorsey, Maryland | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc. | | Baltimore, Maryland | | JUL 28 1982 | | <u>Charles J. Ruck</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 9 6
REG. NO.

| | | | | | |
|---|---|---|--|--|---|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | M | |
| Katherine E. Kimmerle | | 7-31-82 | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | 12-12-1896 | 85 | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| Balto. City | U.S.A. | | Baltimore City MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Baltimore | 505 N. Luzerne Avenue 21205 | | Home Maker | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| Md. | | | Balto. | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | 505 N. Luzerne Ave.-21205 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | 214-74-0456 215-05-5998 | Mrs. Katherine E. Redding - 2601 Mountain Rd. Joppa, Md. 21085 | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9, 19 77, to 8, 19 82 that (I) (we) last saw the deceased alive on 7/2 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| | | | | 8/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| D.W. MACDONALD M.D. | | 9 S. HIGHLAND AVE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 8-3-82 | Parkwood Cem. | | Balto. Md. |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John C. Miller Inc-6415 Belair Rd.-21206 | | AUG - 3 1982 | | Frances Jean Nathan | |

MEDICAL CERTIFICATION

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0702 BP

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Page 4 may be filed with the registrar or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

DHMH - 16 50M 1/81
(VRA 15, 4)

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 7 9 7
REG. NO.

| | | | | | |
|--|------------------|--|---|---|-----------------|
| 1. DECEASED NAME (TYPE OR PRINT) WASHINGTON ROLLINS KING | | | 2a. DATE OF DEATH MONTH DAY YEAR 07 08 82 | | 2b. HOUR A M |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 01 12 02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2115 RAMSAY STREET, 21223 | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIMOUSINE DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY BWI AIRPORT | | 13a. STREET ADDRESS 2115 RAMSAY STREET, 21223 | |
| 13b. STATE MARYLAND | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-10-2167 | | 17. INFORMANT AUDREY AMMONS 2115 RAMSAY STREET, 21223 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD, chronic obstructive pulmonary disease 4960 Abdominal aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1/74, 19, to 8-11, 19 81, that (I) (we) last saw the deceased alive on 8/11/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE LAURENCE GALLAGER, M.D. | | | | 22c. DATE SIGNED 7/9/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE GALLAGER, M.D. | | | | 22e. ADDRESS ST. AGNES MEDICAL CENTER | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT | | 23b. DATE 07-12-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PK. MAUSOLEUM | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | 23e. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 23f. REGISTRAR'S SIGNATURE Renee J. [Signature] | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 24b. ADDRESS 21229 | | 24c. DATE REC'D. BY REGISTRAR JUL 9 1982 | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7798

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--------------------------|--|--------------------------------------|--|------|--|------|--|------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 7a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 7b. HOUR | |
| | | Edward | | C. | | Kirk | | | | XX | | 7 | | 26 | | 1982 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 7d. HOUR | |
| Male | | White | | July 11, 1908 | | 74 YRS. | | | | 7 | | 30 | | 1982 | | | | 11:02 a.m. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | WIDOWED | | DIVORCED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Maryland | | U.S.A. | | <input type="checkbox"/> | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | Baltimore City, | | | | | | MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | |
| Baltimore | | 3501 St. Paul St., Apt. 135 | | Welder | | Beth Steel | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3501 St Paul St | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | FIRST | | MIDDLE | | LAST | | | | | | | | | |
| Clarence | | C | | Kirk | | Charlotte | | | | Chase | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | | | |
| No | | 213-07-1318 | | George Kirk | | 1316 Sherwood Ave | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Arteriosclerotic Cardiovascular Disease | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 4292 | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | (c) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | Assistant | | 7-30-82 | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | | | | | | | | | | | | | | |
| Hormez R. Guard, M.D. | | 111 Penn Street | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| Burial | | Aug 4, 1982 | | Lorraine | | Baltimore, Maryland | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| Leonard J Ruck Inc. | | Baltimore, Maryland | | AUG - 4 1982 | | Frances Jean Warren | | | | | | | | | | | | | |

0 6 1 9 7 8 2 0 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 82 17799

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | MINNIE I. KIRKNESS | | | | July 11, 1982 | | 3:30 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | July 8, 1882 | | 100 YRS. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Baltimore City MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Baltimore | | Union Memorial Hospital | | Bookkeeper | | Photo-Finish-ing | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | | | Baltimore | | | | 3909 Juniper Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Patrick King | | ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 213 74 7646 | | Mrs. Minnie Jachens, Balto., Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4292 | | Cardiac arrest | | A-S Cardiovascular disease | | 5 min | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | Generalized A-S | | 10 yr | | | |
| | | | | | | 10 yr | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| Fx shoulder - 7/10/82 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/13, 1952, to 7/11, 1982, that (I) lost saw the deceased alive on 7/12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | |
| | | Dr. Norman R. Freeman, M.D. | | 7/12/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 22f. DATE REC'D. BY REGISTRAR | | 22g. REGISTRAR'S SIGNATURE | | | |
| Dr. Norman R. Freeman, M.D. | | 11 W. 29th St., Balto., Md. 21218 | | JUL 15 1982 | | Norman R. Freeman | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 7/14/82 | | Druid Ridge | | Pikesville, Maryland | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Henry W. Jenkins & Sons Co. | | 4905 York Road Balto., Md. 21212 | | JUL 15 1982 | | Norman R. Freeman | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

11/11/55

WATKINS, I. J. (1911-1955)

Wife: Mary J. Watkins

Children: 1. James I. Watkins

2. Union Memorial Hospital

3. Baltimore, Md.

4. 1911-1955

5. 1911-1955

6. 1911-1955

7. 1911-1955

8. 1911-1955

9. 1911-1955

10. 1911-1955

11. 1911-1955

12. 1911-1955

13. 1911-1955

14. 1911-1955

15. 1911-1955

16. 1911-1955

17. 1911-1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 3 0 0 REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST August MIDDLE Charles LAST Kirschner, Sr. <i>August Charles Kirschner</i> | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>July 14 1982</i> | | 2b. HOUR <i>7:55 AM</i> | |
| 3 SEX <i>Male</i> | | 4 RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>10 11 1898</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Baltimore</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Steel Worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i> | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Edgemere</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>8108 North Point Road</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles H. Kirschner</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Piles</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-09-2055</i> | | 17. INFORMANT ADDRESS <i>2012 Denbury Dr. Balto., MD.</i> | | | | 17. ADDRESS <i>21222</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4960 IMMEDIATE CAUSE (a) Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>years</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Blair J. Andrew MD.</i> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <i>14 July 1982</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Blair J. Andrew</i> | | | | 22e. ADDRESS <i>Baltimore City Hospital</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | 23b. DATE <i>7/15/1982</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>Duda-Ruck, Inc.</i> | | | | ADDRESS <i>7922 Wise Avenue Dundalk, MD. 21222</i> | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 15 1982</i> | | 25b. REGISTRAR'S SIGNATURE <i>Frances Santhorne</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 666-3373.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 8217801 | | | |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM KISSER, SR. | | | | 7/30/82 | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR March, 17, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 78 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Beth. Steel | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Augustave ----- Kissner | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie ----- Baldwin | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES: NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215-05-9573 | |
| 17. INFORMANT ADDRESS Mr. William D. Kissner, Jr. 313 6th. Ave. Balto. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 1890 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic hypernephroma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/30, 19 82, to 7/30, 19 82, that (I) (we) lost saw the deceased alive on 7/30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above. (If we) (I) did not view the body after death. | | | | | | | |
| 22b. SIGNATURE Margaret Keeler | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/30/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGARET KEELER, M.D. | | 22e. ADDRESS MERCY HOSPITAL 21203 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Aug. 3, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR McClully Funeral Home, 130 E. Front Ave. Balto. Md. | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 0 2

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) SARAH J. KLEIN | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 17 1982 | | | 2b. HOUR 8 A M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 7/22/07 XXXXXX | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3121 BANCROFT RD (21215) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson | | 12b. KIND OF BUSINESS OR INDUSTRY HECHT CO. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO. | | 13b. COUNTY | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3121 BANCROFT RD | |
| 14. FATHER'S NAME LOUIS MIDDLE JUREN | | | | 15. MOTHER'S MAIDEN NAME EVA MIDDLE MANDELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 218-28-6768 | | 17. INFORMANT ADDRESS HERBERT F. KLEIN 14017 BLAZER LA. S.S. MD (20906) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 3949 DUE TO, OR AS A CONSEQUENCE OF (b) MITRAL VALVE DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) NONE | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/20/79 , 19 82 , to 6/24 , 19 82 , that (I) (we) lost saw the deceased alive on 6/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE John Meyerhoff, MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/18/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MEYERHOFF | | | 22e. ADDRESS 2435 W. BELVEDERE AVE. 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) C R EMATION | | 23b. DATE 7-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 23 1982 James Van Natten | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 0 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARVIN R. KNIGHT | | | 2a. DATE OF DEATH MONTH 7 DAY 29 YEAR 82 | | | 2b. HOUR 3:10P | | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH 11 DAY 25 YEAR 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W-VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN US CITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO MD | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COAL MINER | | 12b. KIND OF BUSINESS OR INDUSTRY MINING | | |
| 13a. STATE MD. | | | 13b. COUNTY - | | 13c. CITY OR TOWN BALTO. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 3006 PINESWOOD AVE. | |
| 14. FATHER'S NAME FIRST ELZA MIDDLE KNIGHT LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST ORA MIDDLE BEAMER LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. W.W.II 232 14 7620 | | 17. INFORMANT ADDRESS Mrs. Jennie K. Ittner - 3006 Pineswood Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ypc Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr ypc | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic obstructive lung disease | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that X (this hospital) attended the deceased from May 17 19 82 , to July 29 19 82 , that X (we) lost saw the deceased alive on July 29 19 82 , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Joseph Reilly | | | | | DEGREE MD | | 22c. DATE SIGNED 7/29/82 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH Reilly | | | | | 22e. ADDRESS 3900 Loch Raven Blvd. Baltimore, Md 21218 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 8-1-82 | | 23c. NAME OF CEMETERY OR CREMATORY END OF TRAIL Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE CLINTONVILLE W.VA. | | | |
| 24. FUNERAL DIRECTOR NAME John Miller ADDRESS 7527 Harford Rd. | | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 30 1982 | | 25b. REGISTRAR'S SIGNATURE Jessie San Martin | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

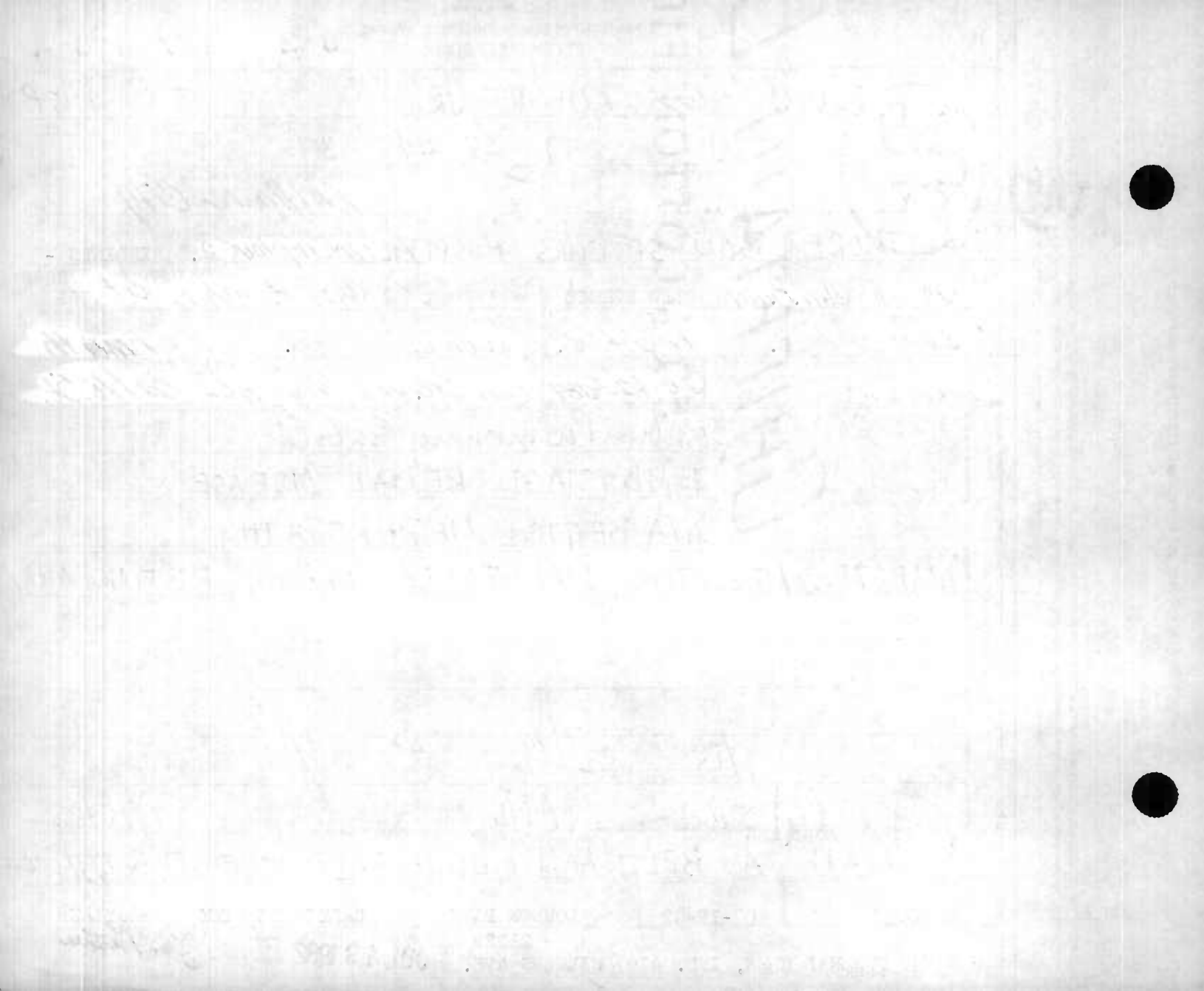
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 8 0 4 | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MELVIN G KNIGHT JR. | | | | | | 2a. DATE OF DEATH MONTH 7 DAY 15 YEAR 82 | | 7b. HOUR 4:15 P. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH 9 DAY 25 YEAR 44 | | 6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. | | 7c. UNDER 1 YEAR MONTHS DAYS HOURS MINS | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATIONS MGR. | | 12b. KIND OF BUSINESS OR INDUSTRY AIRLINES - | | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN A.A. | | 13c. CITY OR TOWN GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS FREIGHT & EXPRESS 5821 RITCHIE STREET, 21061 | | | |
| 14. FATHER'S NAME MELVIN G. KNIGHT SR. | | | | 15. MOTHER'S MAIDEN NAME LEONA L. LEHMUTH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 220-42-9187 | | 17. INFORMANT ADDRESS GLEN BURNIE, MD. KATHRYN E. KNIGHT 5821 RITCHIE STREET | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) possible Pulmonary Emboli 2503 DUE TO, OR AS A CONSEQUENCE OF: (b) END STAGE RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) DIABETIC NEPHROPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) DIABETES MELLITUS, DIABETIC NEUROPATHY, RETINOPATHY | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/14 19 82 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1940 W. BALTIMORE ST. BALTIMORE MD 21223 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14 19 82 to 7/15 19 82 , that (I) (we) lost saw the deceased alive on 7/15 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE JUAN A. BELTRAN MD. | | | | | | | | 22c. DATE SIGNED 7/15/82 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. BELTRAN | | | | | | | | 22f. ADDRESS 1940 W. BALTIMORE ST. BALTIMORE MD 21223 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 07-19-82 | | 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC., 4107 WILKENS AVE. | | | | | | 24b. ADDRESS 21229 | | 25a. DATE REC'D BY REGISTRAR AND REGISTRAR'S SIGNATURE JUL 19 1982 <i>James J. Nathan</i> | | | |

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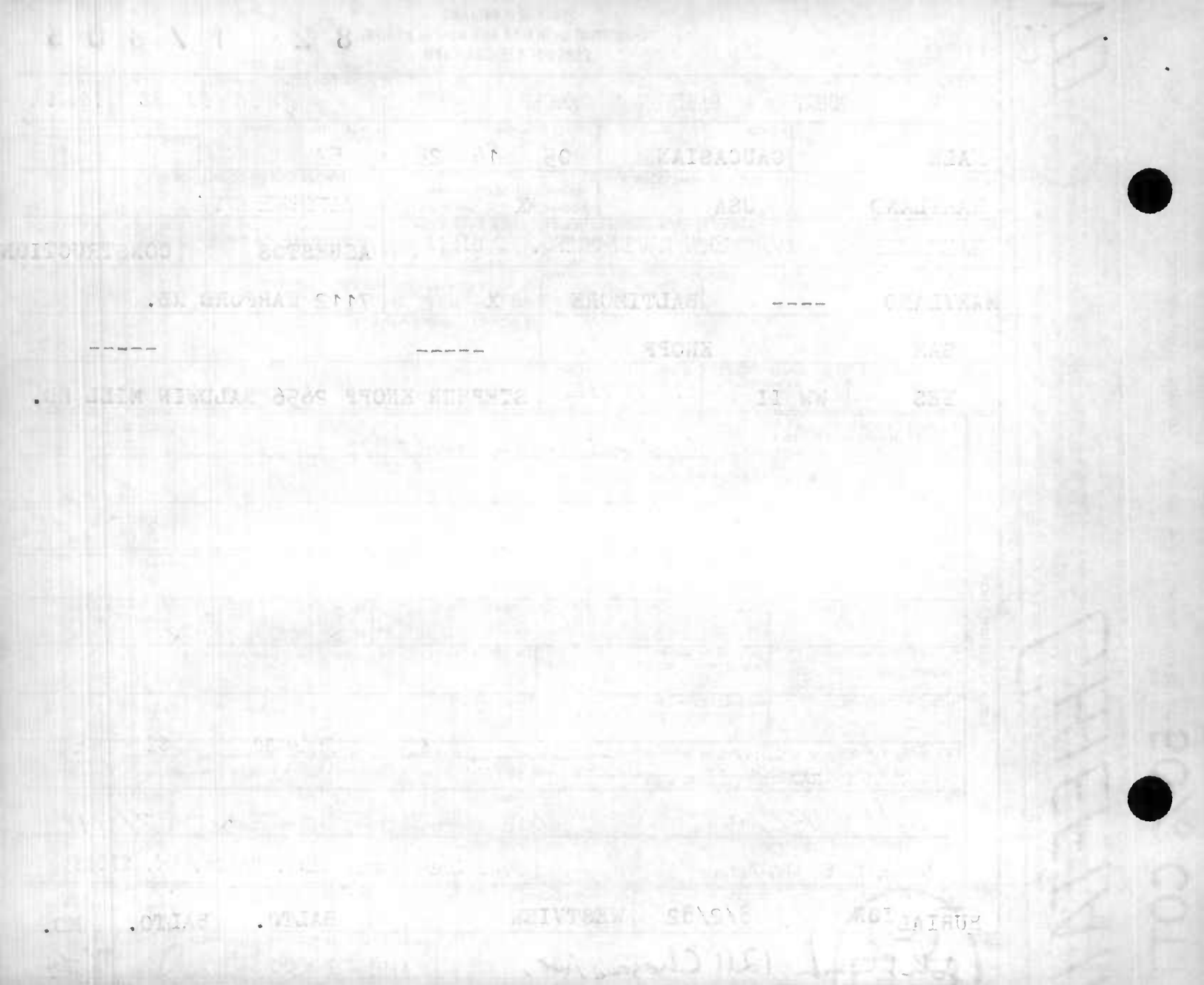


STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROBERT CLIFTON KNOPP | | | 2a. DATE OF DEATH MONTH 7 DAY 30 YEAR 82 | | | 2b. HOUR 10:55A | | | | | | |
| 3. SEX MALE | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH 05 DAY 16 YEAR 25 | | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS HOURS 0 MIN. 0 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION VAMC LOCH RAVEN BALTO. MD 21218 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASBESTOS | | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | | |
| 13a. STATE MARYLAND | | | | 13b. COUNTY --- | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7112 HARFORD RD. | | |
| 14. FATHER'S NAME FIRST SAM MIDDLE --- LAST KNOPP | | | | 15. MOTHER'S MAIDEN NAME FIRST --- MIDDLE --- LAST --- | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS STEPHEN KNOPP 2656 BALDWIN MILL RD. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 3249 IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Epidural abscess APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 days 3.25 days | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: --- | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from July 5, 1982 , to July 30, 1982 , that (X) (we) last saw the deceased alive on July 30, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Robert E. Hertka | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7/31/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Hertka | | | | 22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md. 21218 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL CREMATION | | | | 23b. DATE 8/2/82 | | 23c. NAME OF CEMETERY OR CREMATORY WESTVIEW | | | 23d. LOCATION CITY OR TOWN BALTO. COUNTY BALTO. STATE MD. | | | |
| 24. FUNERAL DIRECTOR NAME John J. Coak ADDRESS 1211 Chesapeake Ave. | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | | 25b. REGISTRAR'S SIGNATURE Frances Van Nuthen | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 8 | 2 | 1 | 7 | 3 | 0 | 6 |
|--|--|--|--|--|--|---|---|------------------------------------|---|--|---|--|--|--------------------------------|--|---|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ISAAC KNOX | | | | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1982 | | | | 2b. HOUR M | | |
| 3. SEX MALE | | | 4. RACE BLACK | | | 5. DATE OF BIRTH MONTH DAY YEAR 5 9 23 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4112 KATHLAND AVE. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SIDNEY KNOX | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA MOULTON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 216-16-9058 | | | 17. INFORMANT ANNIE KNOX | | ADDRESS 4112 KATHLAND AVE. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5789 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) GI bleed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds days days | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 6, 1982 , to July 27, 1982 , that (I) (we) last saw the deceased alive on 5:15 AM July 27, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Mary E. Sunday MD | | | | | | | | | | DEGREE MD | | 22c. DATE SIGNED 7/27/82 | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. SUNDAY | | | | | | | | | | 22e. ADDRESS John's Hopkins Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL BURIAL | | | | | 23b. DATE 7-31-82 | | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | | | |
| 24. FUNERAL DIRECTOR NAME E. L. PHILLIPS | | | | | | | | | | ADDRESS 1721 - 27 N. MONROE ST. | | | 25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE JUL 28 1982 | | | |

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UNITED STATES

DEPARTMENT OF

GENERAL INVESTIGATIVE DIVISION

REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 0 7

REG. NO.

| | | | | | |
|--|-----------------------------|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Darlene J. Koehler | | 2a. DATE OF DEATH MONTH DAY YEAR 7 6 82 | | 2b. HOUR 3:10 PM | |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR 4 28 59 | | 6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Programmer | | 12b. KIND OF BUSINESS OR INDUSTRY Berk | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Balt. 13d. CITY OR TOWN Balt. 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13f. STREET ADDRESS 1820 Wilhelm Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frederick | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anta Thomas | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | |
| 17. SOCIAL SECURITY NO. 215-68-1007 | | 18. INFORMANT Mr. Frederick G. Koehler same | | 19. ADDRESS 1547 E. Monument St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Severe Restrictive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Systemic Lupus Erythematosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Polyarthritis, Polyneuritis, Avascular Necrosis, Proteinuria | | | | | |
| 19a. DATE OF OPERATION 7/6/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Avascular Necrosis of Hips | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Not applicable | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1982 , to July 6, 1982 , that (I) (we) lost saw the deceased alive on July 6, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE H. Steiman | | DEGREE MD | | 22c. DATE SIGNED 7/6/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Steiman | | 22e. ADDRESS 1547 E. Monument St. Balt., Md 21205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 10, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | |
| 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 | | 25b. REGISTRAR'S SIGNATURE Phyllis Jan Whitham | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

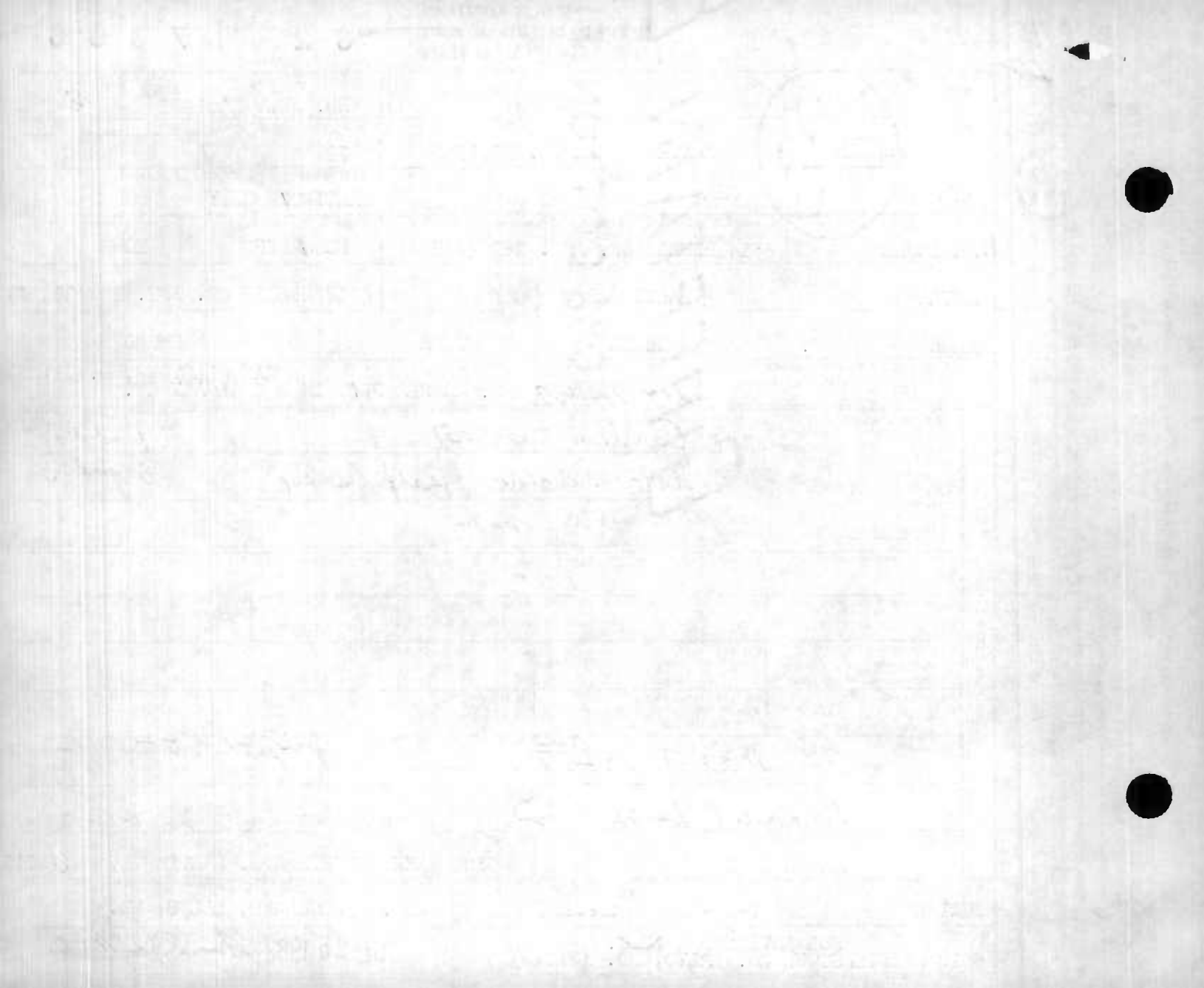
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | |
|--|-------------------------|--|--|---|--------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FANNIE KOMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR WED. JULY 21, 1982 | | 2b. HOUR 8 P M | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 15, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6614 EBERLE DR. APT. 202 (21215) | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | | 13a. STREET ADDRESS 6614 EBERLE DR. APT. 202 (21215) | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST AARON S. ZEMEL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TEMA UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-74-1469 | | 17. INFORMANT ADDRESS RANDALLSTOWN, MD. (21133) MRS. MARSHA PLOTKIN 9 C ALGARY CT. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) non Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 8 19 57 to July 21 19 82 that (I) (we) last saw the deceased alive on May 17 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Manuel Levin MD | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-22-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN | | 22e. ADDRESS 6101 PARK HEIGHTS AVE. BALTIMORE, MD (21215) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (IF BURIAL) BURIAL | | 23b. DATE 7-23-82 | | 23c. NAME OF CEMETERY OR CREMATORY SHAAREI TFILOH CEM. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE WOODLAWN, BALTO, MD. | | 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO, MD. (21215) | | | | |
| 25a. DATE REC'D BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE James J. [Signature] | | | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 0 9

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES J KOOFER | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 21 82 | | | 2b. HOUR 8:02A | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 10 18 13 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) 68 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Maintenance | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Parkville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 2802 Clearview Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles F. Koofor | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Geesey | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | 16b. SOCIAL SECURITY NO. 162-12-4994 | | 17. INFORMANT ADDRESS Mrs. Josephine M. Koofor same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cardio-Respiratory arrest. 15 mts DUE TO, OR AS A CONSEQUENCE OF (b) RT. SIDED CVA RECENT (7/10/82). DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Atherosclerotic Cardiovascular disease. | | | | | | | | | | |
| 19a. DATE OF OPERATION 7/8/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BLADDER CARCINOMA GRADE III | | | | 20a. AUTOPS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N.A. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N.A. | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 7/7/82 , to 7/21/82 , that (we) last saw the deceased alive on 7/21/82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Syed Mohsin Ali Hassan M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/21/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) SYED. MOHSIN ALI HASSAN | | | | | | 22e. ADDRESS NO. CHARLES GEN. HOSP BALTO. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE July 24, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Grand View | | 23d. LOCATION CITY OR TOWN COUNTY STATE Altoona Pa. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 21 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jan Nathan | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. 8 2 1 7 8 1 0 | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST <u>Joyce H. Krakovitz</u> | | MONTH DAY YEAR <u>7 31 82</u> | |
| 3. SEX <u>Female</u> | | 2b. HOUR <u>0650AM</u> | |
| 4. RACE <u>CAUCASIAN</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 5. DATE OF BIRTH MONTH DAY YEAR <u>1 29 34</u> | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <u>48</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Baltimore</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sinai Hospital</u> | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | |
| 13a. STATE <u>MD</u> | | 13b. STREET ADDRESS <u>2214 Oxeeye Rd. #21209</u> | |
| 13c. CITY OR TOWN <u>Baltimore</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>HERMAN TABOR</u> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MABLE STERN</u> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>XXXXXXXXXX NO</u> | | 16b. SOCIAL SECURITY NO. <u>059-26-3957</u> | |
| 17. INFORMANT <u>MR. ALAN H. KRAKOVITZ</u> | | 17. ADDRESS <u>2214 OXEYE RD. #21209</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>1749</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>anemia, multiple rib fractures</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic breast Ca</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-12</u> , 19 <u>82</u> , to <u>7-31</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not view the body after death, so state.) | | | |
| 22b. SIGNATURE <u>Brian Mulkerin, MD</u> | | 22c. DATE SIGNED <u>7-31-82</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mulkerin, Brian</u> | | 22e. ADDRESS <u>320-H Limestone Valley Dr., Cockeysville, Md 21030</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>8-1-82</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON (CHIZUK AMUNO)</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE MD</u> | |
| 24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON & BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u> | | 25a. DATE REC'D. BY REGISTRAR <u>AUG - 5 1982</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) NORMAN KRAMER | | | 2a. DATE OF DEATH MONTH DAY YEAR July 15 82 | | | 2b. HOUR 5:10 PM | | | |
| 3. SEX male | | 4. RACE ca. WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 - 11 - 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Livingdale AGED HOME | | | | 12a. USUAL OCCUPATION COMPLAINANCE DIRECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | |
| 13a. STATE M.D. | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN TOWSON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEON KRAMER | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE MARKOWITZ | | 13e. STREET ADDRESS 923 ELLENDALE DR. 21204 | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. WWII-NAVY 156-16-2847 | | 17. INFORMANT ADDRESS MRS. SUE KRAMER 923 ELLENDALE DR. 21204 TOWSON, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 1850 IMMEDIATE CAUSE (a) CANCER OF Prostate with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CANCER OF Prostate x 10 yrs. | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/13/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (this hospital) attended the deceased from 7/13/82 to 7/15/82 that (we) lost saw the deceased alive on 5:05pm 7/15/82 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 7/15/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KHIN - M. TUN | | | 22e. ADDRESS 2110 Pot Spring Road Md 21093 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE July 19, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY CEM. DULANEY VALLEY MEMORIAL | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 23 1982 [Signature] | | | | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | | | | | |

RECEIVED

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

Office of the Director
Washington, D.C.

Enclosure

X

July 22

1964



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 1 2

REG. NO.

| | | | | | | |
|--|--|--|--|---|----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) NAOMI Ruth KRAUK | | | 2a. DATE OF DEATH MONTH DAY YEAR JULY 19 1982 | | 2b. HOUR 6:34 AM | |
| 3. SEX FEMALE | | 4. RACE White Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR March 7, 1907 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | 8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13. CITY OR TOWN OF DEATH BALTIMORE | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George M Resch | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina Rohrig | | 16. SOCIAL SECURITY NO. 214-22-1400 | | |
| 17. INFORMANT Mr Frederick Krauk | | 18. ADDRESS Same | | 19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) OVARIAN CA. DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | | |
| 21a. DATE OF OPERATION | | 21b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (this hospital) attended the deceased from JULY 16 , 19 82 , to JULY 19 , 19 82 , that (we) last saw the deceased alive on JULY 19 , 19 82 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE Thomas S. Miller | | 22c. DEGREE M.D. | | 22d. DATE SIGNED JULY 19, 1982 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS S. MILLER | | 22f. ADDRESS M.D. GOOD SAMARITAN HOSPITAL | | 22g. MEDICAL PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/22/82 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith | | |
| 23d. LOCATION Baltimore, Maryland | | 23e. STATE MARYLAND | | 23f. DATE REC'D. BY REGISTRAR JUL 20 1982 | | |
| 24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland | | 24b. ADDRESS | | 24c. REGISTRAR'S SIGNATURE James Van Wathen | | |

BP
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified to autopsify.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 1 3

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Frieda Martha Krenlich | | | 2a. DATE OF DEATH MONTH DAY YEAR July 26, 1982 | | 2b. HOUR 9:40P. M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR July 15, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE COUNTRY Germany | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 10. CITY OR TOWN OF DEATH Baltimore | 11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY GIVE STREET ADDRESS) Long Green Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 13a. STATE Maryland | 13b. COUNTY P.G. | 13c. CITY OR TOWN Riverdale | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 6507 Kenilworth Ave. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST August Jente | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mathilde Meschter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-74-9588 | | 17. INFORMANT ADDRESS Address Same as No# 13e. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

Cerebral Vascular Accident

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

hrs

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Generalized Arteriosclerosis

yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>9-21-81</u> to <u>July 26, 1982</u> , that (I) (we) lost saw the deceased alive on <u>5-22-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>S. J. Venable, Jr. M.D.</i> | | DEGREE | | 22c. DATE SIGNED 7-26-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. J. VENABLE, JR. M.D. | | 22e. ADDRESS 7215 YORK RD BALTIMORE MD 21221 | | | |

| | | | |
|---|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE July 29, 1982 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood 7 Maryland |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | | 25a. DATE RECEIVED BY REGISTAR JUL 29 1982 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Charles Jones P.O. Box 111, Hattiesville, MS.

July 23, 1963, Rt. Lincoln Cemetery, Hattiesville, MS.

Funeral

July 23, 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 7/73
(VRA 15(4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|------------------------------|--|--|--|--------------------------------------|--|--|---|--|----------|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 8 1 4 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR |
| EMIL KRETSCHMER, SR. | | | | | | | | 7-30-82 | | 6:30 AM |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| M | W | 11-22-1893 | | 88 | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| MARYLAND | U.S.A. | | | | BALTIMORE CITY - MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| BALTO. | | PIMLICO MANOR NURSING HOME | | | | CONTRACTOR | | CONSTR. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | |
| MD | | - | | BALTO. | | | | 5815 BENTON HEIGHTS AVE. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| MAX KRETSCHMER | | | | GERHARDINA - | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | |
| No | | 218-07-6739A | | Mr. John Kretschmer - 3325 Woodside Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4292 ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (1) (this hospital attended the deceased from July 29 1982, to July 30 1982, that (1) I saw the deceased alive on July 29 1982, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (2) I did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| JON SUNSHINE | | | | M.D. | | | | 7/31/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | |
| JON SUNSHINE | | | | 6210 PARK BLVD BALTO, MD. 21215 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| BURIAL | | 8-3-82 | | BALTIMORE CEM. | | BALTO, MD. | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Jortley Miller - 7527 Harford Rd. | | | | AUG - 2 1982 | | [Signature] | | | | |

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CHICAGO, ILL. 6-1-35

MR. JAMES H. HANCOCK, CHICAGO, ILL.

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MR. JAMES H. HANCOCK, CHICAGO, ILL.

MR. JAMES H. HANCOCK, CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 1 5

REG. NO.

| | | | | | |
|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | HOURS MIN. | |
| HENRY JOHN KRIDER | | 7 19 82 | | 3:30A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Male | White | MONTH DAY YEAR | 85 | IF UNDER 24 HRS | |
| | | 5 30 97 | | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Balto. Md. | U.S.A. | | BALTIMORE CITY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| BALTIMORE | VETERANS ADMINISTRATION MEDICAL CENTER | | Steamfitter | | Retired |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | | |
| Md. | Balto. | Timonium | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | | |
| Henry Kreider | | Anna Kriele | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| Yes | | 216 03 4152 | Regina T. Kreider -21 E. Timonium Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a). <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 23, 1982, to JULY 19, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 19, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | 22b. SIGNATURE A. Foong MD | | 22c. DATE SIGNED 7/19/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| A. Foong | | 3900 Loch Raven Blvd. Balto., Md. 21218 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | 7-22-82 | Parkwood Cemetery | | Balto. Md. |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John C. Miller Inc-6415 Belair Rd.-21206 | | JUL 21 1982 | | Francis J. Nathan | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 2 | 1 | 7 | 8 | 1 | 6 | | |
|---|--|--|---|--|---|--|--|--|--|--|---|--------------------------------------|---|---------------------------|---|---|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | |
| FIRST ALEXANDER MIDDLE KROMM, SR. LAST | | | | | | | | | | 7-21-82 10:30 PM | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH March 12, 1896 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 1 HRS HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) Russia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Molder | | | 12b. KIND OF BUSINESS OR INDUSTRY retired | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Catonsville | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS 801 Winters Lane | | | | | | |
| 14. FATHER'S NAME FIRST Adam MIDDLE Kromm LAST | | | | | 15. MOTHER'S MAIDEN NAME FIRST Amelia MIDDLE Unknown LAST | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-7812 | | | 17. INFORMANT ADDRESS Nan L. Kromm, 801 Winters Lane 21228 | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Chronic obstructive lung disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | |
| Chronic organic brain syndrome | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22/82 to 7/24/82 that (I) (we) lost saw the deceased alive on 5/22/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE MOGET GEREMM MD | | | | | | | | | | DEGREE | | | 22c. DATE SIGNED 7/24/82 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kromm | | | | | | | | | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/23/82 | | | 23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR 1630 Edmondson Ave., Catonsville, MD Witzke Catonsville Funeral Home, P.A. 21228 | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE JUL 23 1982 Frances Van Patten | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove card papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1 DECEASED NAME (TYPE OR PRINT) | | 3 SEX | | 4 RACE | |
| Ethel EVELYN Kropman | | FEMALE | | WHITE | |
| 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. TIME | |
| NOVEMBER 30, 1919 | | 62 YRS. | | 7:00P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | |
| MARYLAND | | U.S.A. | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Baltimore | | Johns Hopkins Hospital | | PARTY CORDINATOR KROPMAN, INC. | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| FRANK CAPLAN | | ANN GASKEL | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 217-26-3118 | | MRS ANN FISHKIN | | 6501 TROTWOOD CT. 21209 | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Adenocarcinoma of Unknown</u> | | | | 7 weeks | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Encephal</u> | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/11/82</u> , 19 <u>82</u> , to <u>7/14</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>7/14</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | |
| H. Parkman | | | | 7/14/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| PARKMAN | | | | Johns Hopkins Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | JULY 16, 1982 | | BALTO. HEBREW CEM | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| SOL LEVINSON & BROS., INC. | | JUL 20 1982 | | James J. Van Thullen | |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 8 1 8 | |
|--|---|---|---|--|--|
| FOR 1. STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) ANNA KUCZ | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 20 82 | | 2b. HOUR 445 PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 11 19 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. MD. | |
| 10. CITY OR TOWN OF DEATH BALTO | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CITY HOSP | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GROCEP | | 12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD | 13b. COUNTY BALTO | 13c. CITY OR TOWN BALTO | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 328 S. Robinson ST | |
| 14. FATHER'S NAME FIRST MIDDLE LAST MATTHEW BYSTRY | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARCIANNA BYSTRY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MELVIN LEJK 413 FOLCROFT ST | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 0389 DUE TO, OR AS A CONSEQUENCE OF (b) UNKNOWN (PRESUMED SEPSIS) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/19 19 82 to 7/20 19 82 , that (I) (we) last saw the deceased alive on 7/20 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | |
| 22b. SIGNATURE Richard A. Josephson | | DEGREE MSMD | | 22c. DATE SIGNED 7/21/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD A. JOSEPHSON | | 22e. ADDRESS BALTIMORE CITY HOSPITAL | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 7-22-82 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART | |
| 23d. LOCATION (CITY OR TOWN) COUNTY STATE BALTO MD | | 23e. DATE REC'D. BY REGISTRAR JUL 23 1982 | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS JOHN M. WEBER 4509 BIRCH ST | | 25. REGISTRAR'S SIGNATURE Charles Jan | | | |

QNDP

WATKIN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 8 1 9 | |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) <i>NAOMI MAY KYTE</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>07-27-82</i> | | | | 2b. HOUR <i>1004 PM</i> | |
| 3. SEX <i>F</i> | | 4. RACE <i>Cauc</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>05 09 16</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>BALTIMORE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>BALTIMORE CITY HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE <i>MD</i> | | 13b. COUNTY <i>BALTIMORE</i> | | 13c. CITY OR TOWN <i>DUNDALK</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>2542 LIBERTY PKWY</i> | | 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>FRANKLIN ECKER</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH GONE</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. <i>215.42.7325</i> | | 17. INFORMANT ADDRESS <i>THEODORE F. KYTE, SR. Same as 13E</i> | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <i>4349</i> IMMEDIATE CAUSE (a) <i>Bradycardia, arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypotension, pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral Infarct with Hemiation</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i> <i>7 hrs.</i> <i>5 d</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i></i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7 22 82</i> P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) <i>this hospital</i> attended the deceased from <i>Jul 27 19 82</i> to <i>Jul 27 19 82</i> , that (I) <i>we</i> lost the deceased alive on <i>Jul 27 19 82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Vikas Saini</i> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <i>7-27-82</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VIKAS SAINI</i> | | | | 22e. ADDRESS <i>4940 Eastern Ave</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i> | | | | 23b. DATE <i>7/30/82</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>MEADOWRIDGE</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>ELKRIDGE MD</i> | | | |
| 24. FUNERAL DIRECTOR NAME <i>WALTER BROOKS BRADLEY, INC.</i> ADDRESS <i>DUNDALK, MD</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JUL 29 1982</i> 25b. REGISTRAR'S SIGNATURE <i>Frances Santhorn</i> | | | | | |

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a medical certification completed.

MEDICAL CERTIFICATION

| | | | |
|--|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/29/82 | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk. | 23d. LOCATION CITY OR TOWN Baltimore COUNTY Co. STATE MD |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i> | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Respiratory Arrest & Hypercalcemia DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Pleural Effusion DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Hypernephroma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH onset of dx 6/25/82 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that (I) (this hospital) attended the deceased from July 22, 1982 to July 24, 1982 , that (I) (we) lost saw the deceased alive on July 24, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | |
| 22b. SIGNATURE <i>Alicia A. Cool-Foley</i> | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED 7/24/82 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alicia A. Cool-Foley | 22e. ADDRESS 201 E University Pkwy Baltimore MD 21208 | |

| | | | | | | |
|---|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 8 2 1 7 8 2 0 REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN LAMB | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 24 82 | | 2b. HOUR 105 A.M. | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 9 16 10 | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | 13b. COUNTY | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS 2128 Aiken St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Lamb Brailford | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Simmons | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Alice Mae Bailey 5220 York Rd. | | |

1. DECEASED NAME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)**No**

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

ADDRESS

Alice Mae Bailey 5220 York Rd.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1991

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Respiratory Arrest & Hypercalcemia**Metastatic Pleural Effusion****Metastatic Hypernephroma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

onset of dx 6/25/82

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **July 22, 1982** to **July 24, 1982**, that (I) (we) lost saw the deceased alive on **July 24, 1982**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

7/24/82

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

Alicia A. Cool-Foley**201 E University Pkwy Baltimore MD 21208**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7/29/82

23c. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Pk.

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

Co. MD

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H 1101 E. North Ave.

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUL 26 1982 James J. Nathan

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 7 8 2 1
REG. NO.1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|--|---|---|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) SUSAN CRAWFORD LANGFORD | | | 2a DATE OF DEATH MONTH DAY YEAR July 20, 1982 | | | 2b HOUR 7 P.M. | | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 10 10 88 | | 6 AGE (IN YEARS LAST BIRTHDAY) 93 | | 7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County City MD | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 710 Brookwood Rd. 21229 | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY Home | |
| 13a STATE Maryland | | 13b COUNTY | | 13c CITY OR TOWN Baltimore | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> XXXX | | 13e STREET ADDRESS 710 Brookwood Rd. 21229 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Thomas Evans Foster | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane McLean | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO. 212-74-3970 | | 17. INFORMANT ADDRESS Roland E. Langford Same as #13 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Disease 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Arterial Sclerotic Cardio Vascular Disease (c) DUE TO, OR AS A CONSEQUENCE OF Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (this hospital) attended the deceased from 19 88 to 7-20 19 82, that (I/we) last saw the deceased alive on 7-19 19 82, and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not view the body after death. | | | | | | | | | |
| 22b SIGNATURE H. Henderson MD DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c DATE SIGNED 7/21/82 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) J. Nelson McKay, M.D. | | | | | | 22e ADDRESS 1132 N. Rolling Rd. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b DATE 7/24/82 | | 23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 23d LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, MD | | | | | | 25a DATE REC'D. BY REGISTRAR JUL 23 1982 | | | |
| | | | | | | 25b REGISTRAR'S SIGNATURE James J. Nathan | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 8 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.



Handwritten text, possibly a date or initials, on the left margin.

Handwritten text in the center of the page, possibly a title or main heading.

Handwritten text at the bottom of the page, possibly a signature or footer.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

1- FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
8 2 1 7 8 2 2
REG. NO.

| | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) SALLIE BEATRICE LAWRENCE. | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-24-82 | | | 2b. HOUR MIN. 6:00 P.M. | | | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 05 01 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SBG-H | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | 13b. COUNTY | | 13c. CITY OR TOWN Balt. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 943 Cherryhill Rd | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (Lassie) Oscar Craig | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Mitchell | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-68-4344 | | 17. INFORMANT ADDRESS Chart-Carolyn Williams Evans | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 5849 DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia, subendocardial infarction. DUE TO, OR AS A CONSEQUENCE OF (c) Acute renal failure. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (a) this hospital attended the deceased from 6-30 19 82 , to 7-24 19 82 , that (b) we lost saw the deceased alive on 7-24 19 82 , and that (c) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Michael B. Nestor | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 7-24-82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael B. Nestor | | | 22e. ADDRESS 3001 S. Hanover, Balt., M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Weldon N.C. | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave. | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 26 1982 | | 25b. REGISTRAR'S SIGNATURE Francis Van Natter | | | |



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July 2, 1963

Letter to

Director

Salisbury, Maryland

Salisbury General Hospital

Salisbury

Re: [illegible]

Enclosure of [illegible]

July 2, 1963

Re: [illegible]

July 2, 1963

Enclosure of [illegible]

Enclosure of [illegible]

3
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|----------------------|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) ELIZABETH LAYTON | | 2a. DATE KNOWN OF DEATH X MONTH DAY YEAR 7 9 82 | | 2b. HOUR 3:10 |
| 3. SEX Female | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 2 2 02 | 6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1516 Edison Highway | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE MD | | 13b. COUNTY Baltimore | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wheeler Layton | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lossie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Raymond Layton 1516 Edison Highway |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE Hormez R. Guard, M.D. | | TITLE (SPECIFY) M.D. Assistant | | DATE SIGNED 7/12/82 |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 111 Penn Street Baltimore, MD 21201 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7/13/82 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | ADDRESS 1101 E. North Ave. | | 25a. DATE REC'D. BY REGISTRAR JUL 13 1982 |
| | | 25b. REGISTRAR'S SIGNATURE Francis J. Nathan | | |

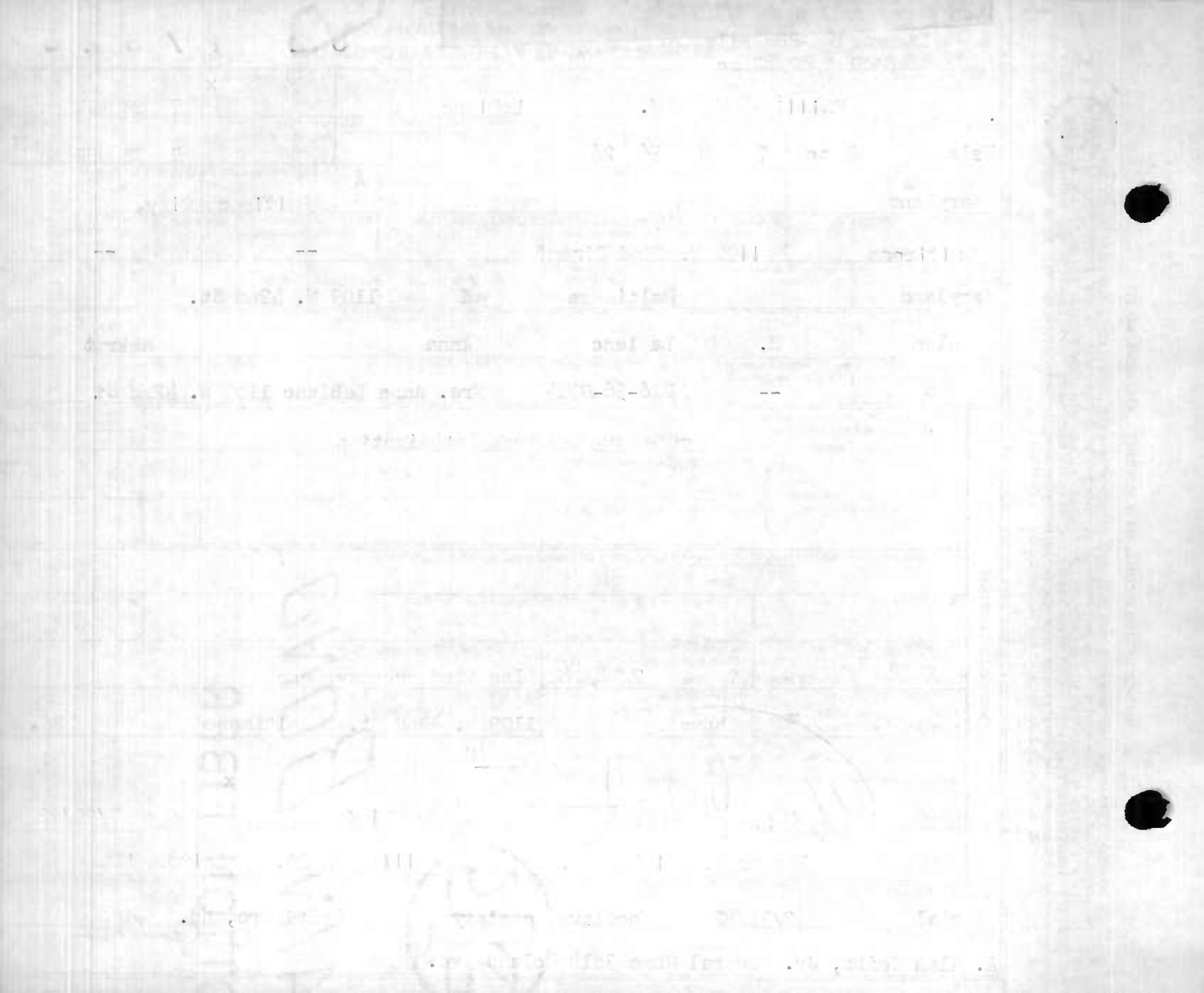
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 17825 | |
|---|------------------|---|------------------------------|---|-----------------------------------|--|--------------------------------|---|---------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Philip Phillip LeBlanc | | | | | | | 2a. DATE OF DEATH 7 28 1982 | | 2b. HOUR 5:21 PM | | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 7 8 56 | 6. AGE (IN YEARS) 26 YRS. | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 7 28 1982 | | 2d. HOUR 5:21 PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1109 W. 42nd Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -- | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13a. STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1109 W. 42nd St. | | | |
| 14. FATHER'S NAME Alan R. LaBlanc | | | | 15. MOTHER'S MAIDEN NAME Anna Rekrut | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- | | 17. INFORMANT Mrs. Anna LeBlanc | | 17. ADDRESS 1109 W. 42nd St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7800 IMMEDIATE CAUSE (a) Acute propoxyphene Intoxication DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/28/82 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ingested propoxyphene | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, WORK, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1109 W. 42nd St. Baltimore Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | DATE SIGNED 7/29/82 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 7/31/82 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr. | | | | ADDRESS Funeral Home 3818 Roland Ave | | | | 25. DATE REC'D. BY REGISTRAR AUG 4 1982 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove cards on pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 8 2 1 7 8 2 6 | |
|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| MARY JEAN LEE | | JULY 22, 1982 | | 9:20A M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| Female | NEGRO | NOV. 9, 1931 | 50 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MARYLAND | USA | BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BALTIMORE | JOHNS HOPKINS HOSPITAL | COOK | | WASHINGTON Coll. | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| MARYLAND | KENT | Chestertown | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | Rt 4 Box 577 | |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 16. SOCIAL SECURITY NO. | | | |
| GEORGE WASHINGTON KENARD | MARY FRANCES COTTEN | 214-28-1365 John Lee | | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 17b. SOCIAL SECURITY NO. | 17. INFORMANT | | | |
| NO | 214-28-1365 | John Lee HUSBAND - SAME | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| 1830 IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) OVARIAN CANCER | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/14, 1982, to 7/22, 1982, that (I) (we) last saw the deceased alive on 7/22, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| F.T. Battig M.D. | | | | 7/27/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| F.T. Battig M.D. | | The Johns Hopkins Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 7-26-82 | | Rich Neck | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| EDW. Fellows + Son | | MIG 2 1982 | | James Jean Nathan | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 2 1 7 8 2 7 | |
|--|--|---|--|---|--|---|----------------------------------|--|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) SADIE LEFKOWITZ | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 07-22-82 | | | 2b. HOUR 920A | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 5 24 1999 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | | |
| 7a. NEW HAMPSHIRE WAXX XXXXXXXX | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GERIATRIC LEVINDALE HEBREW CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. 303 6610 EBERLE DR. 21215 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST RABBI HARRY CANTOR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA ADELMAN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT MISS GERTRUDE CANTOR | | | 6610 EBERLE DR., APT. 303 #21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5997 IMMEDIATE CAUSE (a) PROBABLE ACUTE MYOCARDIAL INFARCT APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ANEMIA (c) HEMATURIA | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) ORGANIC BRAIN SYNDROME | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 07-27 , 19 81 , to 07-22 , 19 82 , that (I) (we) lost saw the deceased alive on 07-22 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE B. ZAW-WIN, M.D. | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7-22-82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-WIN, M.D. | | 22e. ADDRESS LEVINDALE BALTO., MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE JULY 23, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY BALTO. CITY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. HANOVER DA | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | | | | 25a. DATE RECEIVED BY REGISTRAR JUL 28 1982 | | | | | | | |

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2020-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 2 1 7 8 2 8 | | | |
|---|--|---|--|--|--|--|--|---|--|---|-----------|------------|---------------------|
| 1- FOR STATE REGISTRAR | | CERTIFICATE OF DEATH | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST NATHAN | | MIDDLE | | LAST LEMLER | | 2a. DATE OF DEATH | | MONTH 7 | DAY 30 | YEAR 82 | 2b. HOUR 5:31 AM |
| 3. SEX MALE | | 4. RACE CAUC | | 5. DATE OF BIRTH MONTH 9 DAY 18 YEAR 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 9b. CITIZEN OF WHAT COUNTRY? USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD | | 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHARMACIST | | 13. KIND OF BUSINESS OR INDUSTRY DRUG | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL | | 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | 13b. CITY OR TOWN BALTIMORE | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS APT. 402 7121 PARK HTS. AVE. #21215 | | | |
| 14. FATHER'S NAME FIRST ABRAHAM | | MIDDLE | | LAST LEMLER | | 15. MOTHER'S MAIDEN NAME FIRST BESSIE | | MIDDLE | | LAST UNKNOWN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-1819 | | 17. INFORMANT MRS. ROSE LEMLER | | 7121 PARK HTS. AVE., APT. 402 BALTO., MD | | 21215 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4100 DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) MI, ASCVD | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-30-82 to 7-30-82, that (I) (we) last saw the deceased alive on 7-30-82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE PATRICIA A. SNELO | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7/30/82 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS SINAI HOSPITAL | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE AUG. 1, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN | | 23d. LOCATION BALTIMORE COUNTY MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | | 25a. DATE REC'D. BY REGISTRAR AUG - 3 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | | | | | | | | |

item 23d #G570 8/11/82 ph

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 7 8 2 9

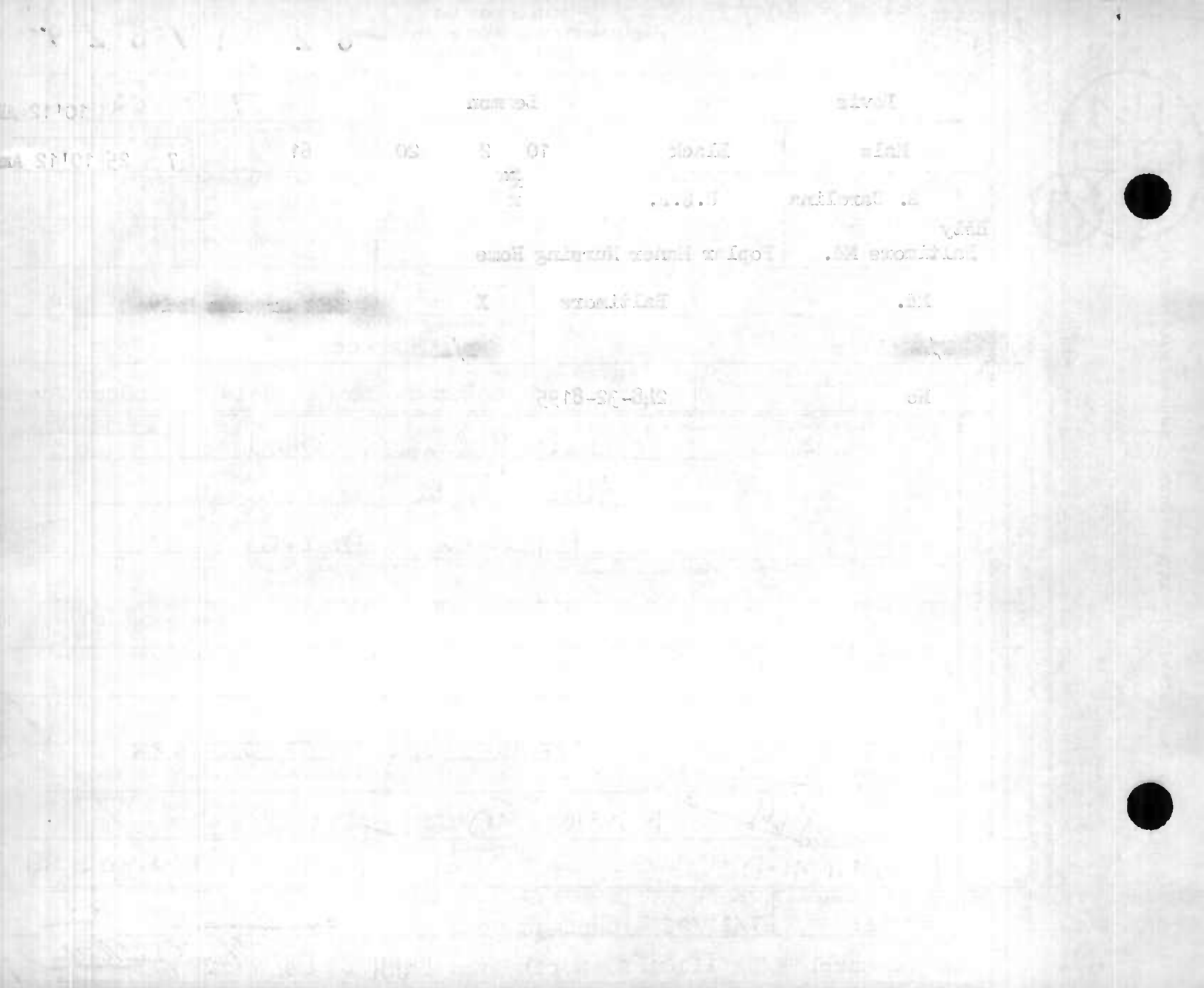
REG. NO.

| | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Davis | | | MIDDLE Lemmon | | | LAST Lemmon | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 82 | | | 2b. HOUR 10:12 AM | | |
| 3. SEX Male | | | 4. RACE Black | | | 5. DATE OF BIRTH MO 10 Y 2 YE 20 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 | | | IF UNDER 1 YEAR N. MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore Md. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Poplar Manor Nursing Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY | | | 13c. CITY OR TOWN Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 3619 Edmondson Avenue | | |
| 14. FATHER'S NAME FIRST Willie MIDDLE LAST Lemmon | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Rebecca MIDDLE LAST Epps | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 248-32-8195 | | | 17. INFORMANT ADDRESS Booker T. Lemmon 3619 Edmondson Avenue | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension + Diabetes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-20-1982 to 7-25-1982 , that (I) (we) lost saw the deceased alive on 7-25-1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE K NAIR | | | | | | | | DEGREE MD | | ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. NAIR, M.D. | | | | | | | | 22e. ADDRESS 5010 York Road BAL MD 21112 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 7/31/82 | | | 23c. NAME OF CEMETERY OR CREMATORY Goodman Cem. | | | 23d. LOCATION CITY OR TOWN Lynch COUNTY S.C. STATE VA | | | | | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 11101 E. North Ave. | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 REGISTRAR'S SIGNATURE [Signature] | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8 2 1 7 8 3 0 | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Julian J. Levasseur | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR July 4, 1982 | | | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 16, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.H. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1309 Park Avenue (Residence) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Navy | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1309 Park Ave. 21217 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Gideon Levasseur | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Not Known | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Navy WW II 325-26-2499 | | 17. INFORMANT J. Hyland Levasseur | | | | ADDRESS Seabrook, Md. 20706 9775 Good Luck Rd #3 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4360 DUE TO, OR AS A CONSEQUENCE OF (b) CVA INVOLVING PONTINE, TEGMENTUM, RETICULAR FORMATION DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-17 , 19 82 , to 6-17 , 19 82 , that (I) (we) last saw the deceased alive on 6-17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Sevillano L. Lugo | | DEGREE M.D. | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/7/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sevillano L. Lugo | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE Jul 8 1982 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 9 1982 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

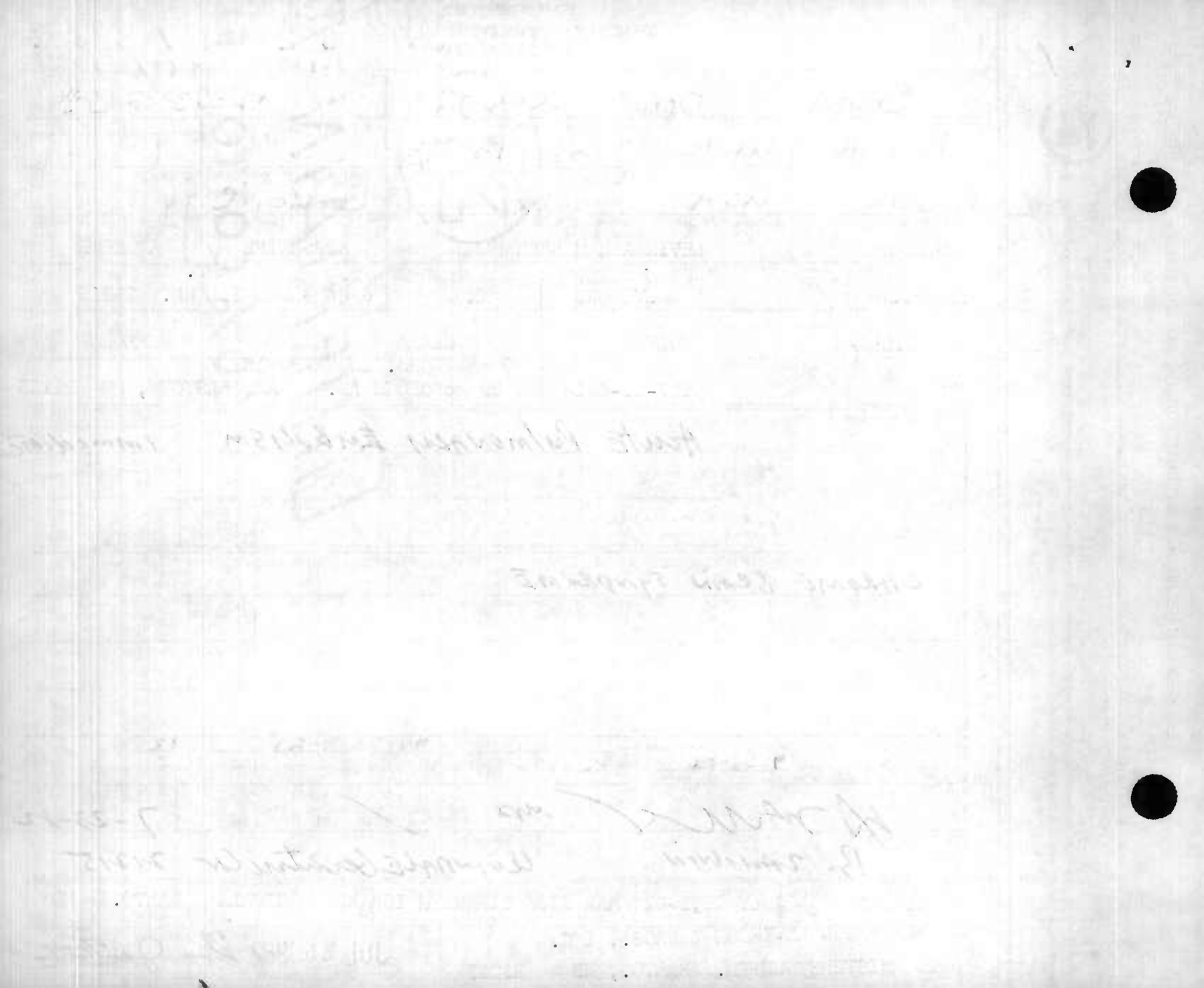
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 8-2 17831 | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (FIRST, MIDDLE, LAST) MILTON LEVEN | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7 28 82 | | 2b. HOUR 11 PM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE UNION MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer | | 12b. KIND OF BUSINESS OR INDUSTRY Law | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Abraham Leven | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Yellin | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 217 22 4383 | | 17. INFORMANT Mrs. Ruth W. Leven | | ADDRESS Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic prostatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4 months | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: stroke | | | | | | | | | | | |
| 19a. DATE OF OPERATION 3/82 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatic Carcinoma | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/27 , 19 82 , to 7/28 , 19 82 , that (I) was last saw the deceased alive on 7/28 , 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above (I did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE David M. Diffley | | | | | | DEGREE MD | | 22c. DATE SIGNED 7/28/82 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Diffley | | | | | | 22e. ADDRESS Union Memorial Hospital 301 University Parkway Baltimore Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/29/82 | | 23c. NAME OF CEMETERY OR CREMATORY Balto. Hebrew | | 23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 29 1982 | | 25b. REGISTRAR'S SIGNATURE Frances VanHatten | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) Sarah DORA Levison | | | | | | 2a. DATE OF DEATH MONTH 7 DAY 23 YEAR 82 | | 2b. HOUR 5:30 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH 08 DAY 12 YEAR 93 | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | 7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | 7. IF UNDER 24 HRS. HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD. | | | | | |
| 10. CITY OR TOWN OF DEATH BALTIMORE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LEVINDALE HEBREW HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY AT HOME | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY BALTO. | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS APT. 1D 6948 BROOKMILL RD. 21215 | | | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE COLVIN LAST CLARA | | | | 15. MOTHER'S MAIDEN NAME FIRST CLARA MIDDLE UNKNOWN LAST UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-6814 | | 17. INFORMANT MRS. LEONA DUBICK 4009 McDONOGH RD. RANDALLSTOWN, MD 21133 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) Acute Pulmonary Embolism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | (b) | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. CHRONIC BRAIN SYNDROME | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET LEVINDALE Geriatric Cn | | CITY OR TOWN BALTO. | | COUNTY MD | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79 to 7-23 19 82 , that (I) (we) last saw the deceased alive on 7-23-82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE B. ZAW-WIN. | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7-23-82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS LEVINDALE Geriatric Cn 21215 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE JULY 25, 1982 | | 23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFERETH ISRAEL | | 23d. LOCATION CITY OF ROSEDALE | | BALTO. MD | |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUL 28 1982 | | 25b. REGISTRAR'S SIGNATURE Thomas J. Nathan | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 7 2 1 7 8 3 3 | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORRNE ANNE E. LEWANDOWSKI | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7/3/82 | | | 2b. HOUR 3 ⁰⁰ P.M. | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3 20 12 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mich. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY CHESS IE SYSTEM | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD | | 13c. CITY OR TOWN BALTO | | 13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 112 BONAIR RD., 21225 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WIRTZ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELINE KADAU | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 363-01-1499 | | 17. INFORMANT ADDRESS Terry Lewandowski Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Pulmonary embolism, bilateral massive DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis large veins of legs DUE TO, OR AS A CONSEQUENCE OF (c) metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Colon carcinoma | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/1 19 82 to 7/3 19 82 that (I) (we) lost saw the deceased alive on 7/3/82 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Karen Ann Newton | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 7/3/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAREN NEWTON | | | | 22e. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/7/1982 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A. A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR NAME McCully Funeral Home | | | | ADDRESS Balto., Md., 21225 237 E. Patapsco Ave., | | 25a. DATE REC'D. BY REGISTRAR JUL 7 1982 | | 25b. REGISTRAR'S SIGNATURE James J. Newton | |

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[Faint, mostly illegible handwriting across the page, possibly representing a list or ledger entries.]

[Faint text at the bottom of the page, possibly a signature or footer.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 17834

| | | | | | |
|--|----------------------|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gary Allen Lewis | | | 2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 28 1982 | | 2b. HOUR M 2:38P |
| 3. SEX MALE | 4. RACE NEGROID | 5. DATE OF BIRTH MONTH DAY YEAR APR 11 1982 | 6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS 3 17 | IF UNDER 24 HRS. HOURS MIN. 2 | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 28 1982 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A | |
| 13a. STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Allen Lewis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Mills | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Carolyn Mills 2751 Tivoli Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | TITLE (SPECIFY) M.D. Deputy Chief | | DATE SIGNED 7/29/82 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS 111 Penn St. Balto., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 7-31-82 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Anne Arundel County, Md. | |
| 24. FUNERAL DIRECTOR NAME Calvin B. SCRUGGS | | ADDRESS 1412 E. Preston St. | | 25a. DATE REC'D BY REGISTRAR AUG - 2 1982 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 7 2 1 7 8 3 5 | |
|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARY Lillian Lewis | | | | 2a. DATE OF DEATH MONTH DAY YEAR 7-2-82 | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 30 24 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. Deaton Medical Center | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MO | | 13b. COUNTY | | 13c. CITY OR TOWN Baltimore | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Beverly Hardaway | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Marshall | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS Henry L. Lewis 6934 Deonachie | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2370 IMMEDIATE CAUSE (a) Chondrocharyngeal & secondary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) hydrocephalous & brain damage DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that on (this hospital) attended the deceased from 7/2 19 82 to 7/2 19 82 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased alive on 7/2 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE J.P. Gladue, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 7/2/82 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7/7/82 | | 23c. NAME OF CEMETERY OR CREMATORY Church Cem. | |
| 24. FUNERAL DIRECTOR NAME Wm. C. March F/H | | 24b. ADDRESS 1101 E. North | | 23d. LOCATION CITY OR TOWN COUNTY STATE Croft Va. | |
| 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE James J. Nathan | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 8 2 1 7 8 3 6 REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST William | | MIDDLE Edward | | LAST Lewis | | 2a. DATE OF DEATH MONTH DAY YEAR July 14, 1982 | | 2b. HOUR 7:40a M |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR Dec 24, 1997 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. | | | | |
| 10. CITY OR TOWN OF DEATH Baltimore | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY AGRI. | | |
| 13a. STATE Md. | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN Sykesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 910 Gibbons Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Wm Lewis | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Whittaker | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215.30 1122 | | 17. INFORMANT May Brooks | | | | ADDRESS Sykesville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Sinus Bradycardia with intermittent supraventricular tachycardia. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from June 29, 19 82, to July 14, 19 82, that x (we) lost saw the deceased alive on July 14, 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. x (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Richard Lane | | | | DEGREE MD | | | | 22c. DATE SIGNED 7/14/82 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Lane, M.D. | | | | 22e. ADDRESS c/o Maryland General Hospital | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 7-17-82 | | 23c. NAME OF CEMETERY OR CREMATORY Sykesville Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Harry W. Haight | | | | ADDRESS Sykesville, Md. | | 25a. DATE REC'D. BY REGISTRAR JUL 15 1982 | | 25b. REGISTRAR'S SIGNATURE Frances Jean Nathan | | |

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